UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK
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GOVERNMENT EMPLOYEES INSURANCE COMPANY, GEICO INDEMNITY COMPANY, GEICO GENERAL INSURANCE COMPANY, AND GEICO CASUALTY COMPANY,

PLAINTIFFS,

vs. Docket No:
20-cv-03495 (FB) (SJB)

ALEXANDR ZAITSEV, M.D., METROPOLITAN INTERVENTIONAL MEDICAL SERVICES, P.C., ANTHONY BENEVENGA, CHARLES G. NICOLA, D.C., RIDGEWOOD DIAGNOSTIC LABORATORY, L.L.C., TRI- STATE MULTI-SPECIALTY MEDICAL SERVICES, P.C., RIVERSIDE MEDICAL SERVICES, P.C., KRISTAPPA SANGAVARAM, M.D., EUGENE GORMAN, M.D., BOGDAN NEGREA, M.D., ANTONIO CICCONE, D.O., STELLA AMANZE, P.A., FRIDA ISAKOV, P.A., LUCKNIE OVINCY, P.A., EMILY BAKERMAN, N.P., MELISSA EVANS, N.P., MINI MATHEW, N.P., ANGELA PULLOCK, N.P., LINDA SANTA MARIA, N.P., AND RIVKA WEISS, N.P.,

DEFENDANTS.
----------X

DATE: April 27, 2023

TIME: 10:06 A.M.

ZOOM VIDEO CONFERENCE TRANSCRIPT of the Rebuttal expert witness, Dr. James Murphy, taken by the Plaintiff, held via videoconference by all participants, before Ariella Vasquez, a Stenographic Court Reporter, and Notary Public of the State of New York.

A P P E A R A N C E S:

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122 East 42nd Street, Suite 725
New York, New York 10168
BY: MATTHEW CONROY, ESQ.

ALSO PRESENT: Colleen O'Neil

* * *

I N D E X

E X H I B I T S

EXHIBITS RETAINED BY: Mr. Henesy

F E D E R A L S T I P U L A T I O N

IT IS HEREBY STIPULATED AND AGREED by and between the counsel for the respective parties hereto, that the filing, sealing, and certification of the within deposition shall be and the same are hereby waived;

IT IS FURTHER STIPULATED AND AGREED that all objections, except as to the form of the question, shall be reserved to the time of trial.

IT IS FURTHER STIPULATED AND AGREED that the within deposition may be signed before any Notary Public with the same force and effect as if signed and sworn to before this court.

Dr. Murphy

D R. J A M E S P A T R I C K M U R P H Y,
called as a witness, having been first duly sworn by a Notary Public of the State of New York, was examined and testified as follows:

BY THE REPORTER:

Q. Please state your name for the record.

A. Dr. James Patrick Murphy.

Q. What is your business address?

A. 101 Rolling Creek, New Albany, Indiana. I don't remember the exact address.

THE REPORTER: Counsel, you may proceed.

EXAMINATION

BY MR. HENESY:

Q. Okay. Good morning, sir.

A. Good morning.

Q. My name is Steve Henesy. I'm an attorney at a law firm Rivkin Radler and I represent Geico, the plaintiffs collectively known as Geico, in a lawsuit that's currently pending in the United States District Court for the Eastern District of New York.

That lawsuit is entitled Government

Employees Insurance Company, et al. v. Alexandr Zaitsev, M.D., et al. And we are here today to take your deposition as you have been designated as a rebuttal expert by various defendants in this case.

Before I proceed any further, sir, are you having any difficulty hearing or seeing me?

A. No, I'm not.

Q. If at any point, you have any difficulty hearing me or seeing me, please let me know so we can resolve whatever issue we're having and we don't have to waste time by repeating testimony because one side couldn't hear what the other is saying.

Is there anyone in the room with you right now?

A. No.

Q. And where are you right now?

A. I'm in my office in New Albany, Indiana.

Q. Do you have any written materials in front of you?

A. No.

Q. I'm going to go over some of the ground rules for this deposition. I understand, sir, that

you have testified before. However, for the purposes of the clarity of the record, I want to advise you of the following: First, this is going to be a question and answer session, that you have just been sworn in under oath. That oath has the same legal force and effect as if you were testifying in a court of law.

Do you understand that?

A. Yes, I do.

Q. The most important person in connection with the deposition is the court reporter, and that is because at some point down the line, we're going to need to read a transcript of today's deposition and understand what happened.

To do that, we need to make sure that only one person is speaking at a time. So I'll ask you to please wait until I finish asking my question before you begin answering it, and I'll reciprocate, I'll wait for you to finish answering my question, in most cases, without interrupting before I ask my next question.

If at -- your answers today must be verbal. Saying mm-hmm or uh-huh or shaking your head or nodding is not sufficient for the purposes

of the record. If at any point today, you want to take a break, you want to use the restroom, you want to stop staring at your computer screen, that's fine. You can take as many breaks as you'd like.

There is a caveat that to the extent that there is a pending question, there is a question that I asked that you have not yet answered, you must answer that question before we take a break.

Do you understand that?

A. Yes.

Q. Do you understand everything that I've said so far?

A. Yes.

Q. Have you taken any drug, alcohol, or substance that would affect your ability to testify truthfully here this morning?

A. No.

Q. And are you prepared to proceed with this deposition?

A. Yes.

Q. Okay. In advance of this deposition, did you do anything to prepare?

A. Yes.

Dr. Murphy

Q. Tell me what you did to prepare.

A. I reviewed the report that I provided counsel and I reviewed some of the materials that I mentioned in my report. And I had a discussion with counsel yesterday briefly in preparation. And then there was a brief discussion this morning.

Q. So you said that you reviewed your report and some of the materials. What materials in particular did you review?

A. The reports from the two experts. And I'm blanking on their exact names right now, but they're mentioned in my report. I reviewed those documents and I reviewed my report.

Q. So besides the two expert reports, Geico's experts, and your expert report, did you review any other documents in preparation for this deposition?

A. No.

Q. You previously indicated that you had a conversation with counsel. Who is counsel?

A. Mr. Conroy.

Q. And you said you spoke to him over the -- you spoke to him yesterday.

Was that over the phone?

A. Yes.

Q. How long did you speak to Mr. Conroy for yesterday?

A. Probably 20 to 30 minutes.

Q. And you said you spoke to him again this morning?

A. Yes.

Q. How long did you speak to him for this morning?

A. It was anywhere from, like, five to ten minutes.

Q. Prior to the phone call today and the phone call yesterday, had you ever spoken to Mr. Conroy before?

A. Yes.

Q. How many times?

A. That, I don't know.

Q. Aside from Mr. Conroy, have you spoken to any other attorneys you understand to be associated with Mr. Conroy or his law firm?

A. Yes.

Q. Who?

A. Mr. Hewitt.

Q. And how have you communicated with Mr.

Hewitt; in other words, by which means?

A. Mr. Hewitt, I believe, texted. We've talked on the phone and via e-mail. I don't recall if we ever had a Zoom conference, but that may have been the case. And I want to amend what I said. I apologize. But yesterday, I might have been talking to both attorneys this -- you know, Mr. Hewitt and Mr. Conroy on my conversation yesterday.

Q. Besides Mr. Hewitt and Mr. Conroy, do you know if anyone else was on the line?

A. To my knowledge, no one else was on the line.

Q. The times that you had spoken to Mr. Hewitt on the phone prior to yesterday, has anyone else been a party to those conversations?

A. Not to my knowledge.

Q. Who initially contacted you about this litigation?

A. I'm not certain, but I believe it was Mr. Hewitt. But I'm not certain.

Q. When were you first contacted about this litigation?

A. It was several weeks prior to the day of the report that I submitted.

Dr. Murphy

Q. So your report is dated March 20th of this year. Would the first contact you would have received been in March or in February?

A. I don't know.

Q. So as part of your preparation for your report -- well, as part of the preparation of the report, fair to say, Doctor, that you reviewed certain written materials?

A. Yes.

Q. Who gave you those written materials?

A. It was either Mr. Hewitt, Mr. Conroy, or both of them.

Q. Were they provided by e-mail?

A. I'm not certain. They may have been provided by a secure link to a Dropbox, or some sort of facility of that nature.

Q. Certainly, they were provided to you electronically?

A. Yes.

Q. What materials were you provided with electronically in advance of the preparation of your report?

A. I had the reports by the experts for Geico. I had some transcripts of some testimony,

and I believe it's by Dr. Zaitsev. And then I had some records, some medical records to review as well. And then there was the complaint. I was able to review that.

Q. All of the materials that you just described, those were the materials that were provided to you electronically by -- we'll just refer to them as counsel?

A. Yes.

Q. Did you make a specific request for any of those materials?

A. Not to my recollection.

Q. When you say you were provided with medical records, can you be a little more specific? What exactly were you provided?

A. I listed this in my report, and I gave initials to certain patients that I had medical records to review. So it's in the report.

Q. So in other words, there are some patients listed by their initials in your report. You reviewed medical records associated with those patients. Is that correct?

A. Yes.

Q. Do you know who selected those patients

as the ones for whom you reviewed records?

A. No.

Q. It certainly wasn't you, right?

A. Correct.

Q. Do you know who decided how many patients' records you would review in connection with preparation of your report?

A. No.

Q. It certainly wasn't you, right?

A. Correct.

Q. Do you know how many total patients are at issue in this litigation; in other words, how many claims are at issue in this litigation?

A. No.

Q. Putting aside whether or not you know the specific number, do you have a ballpark, that you're aware of, of how many patient claims are at issue in this litigation?

A. No.

Q. By extension then, you would agree with me that you do not know what percentage of the total patient population at issue in this lawsuit your review represented?

A. I do not know the percentage.

Dr. Murphy

Q. Did you ever ask anyone at counsels' office how many total patients there were in this case?

A. No.

Q. Did you ever ask anyone at counsels' office what percentage of the total patient population your review represented?

A. No.

Q. Did that matter to you in any way?

A. For the purposes of my report and my opinion, it did not matter.

Q. The medical records that you reviewed -- and I'm talking about the ones that are associated with the patient initials in your report -- do you know how many total pages those records were comprised of?

A. No.

Q. Do you recall if it was more than 500?

A. No.

Q. Do you recall if it was more than 1,000?

A. No.

Q. Was it 10,000?

A. I don't know. I believe it was nowhere

near 10,000.

Q. Was it near 1,000?

A. I don't recall.

Q. In addition to the medical records that you reviewed, you testified that you also reviewed the transcripts of certain depositions.

Is that correct?

A. Yes.

Q. And one of those depositions was with regard to defendant Dr. Zaitsev, right?

A. Yes.

Q. Do you recall how many volumes that transcript was comprised of?

A. No.

Q. In other words, did it appear to you that what you were reviewing was several days worth of testimony or a single day?

A. I can't recall.

Q. Besides Dr. Zaitsev, as you sit here, Doctor, do you recall any other transcripts that you reviewed?

A. Sitting here right now, I can't recall.

Q. Your report indicates that you reviewed the transcript of a Dr. Gorman. Is that true?

Dr. Murphy

A. If it's in my report, that's true.

Q. When you were provided these written materials that we've now discussed, which is the complaint, the two deposition transcripts, and the medical records, did you conduct an initial review of those materials?

A. I conducted a review of the materials. I'm not sure if I would categorize it as an initial review.

Q. After you conducted a review of the written materials that we just discussed, did you ever request from counsel any supplemental materials?

A. Well, first of all, I don't have my report in front of me. And you mentioned a Dr. Gorman's testimony, and I'm going to assume that what you're telling me is true in my report, because I don't recall Dr. Gorman's testimony as I sit here right now.

So with the assumption that what you're telling me is the truth, I believe your question is, what else did I review? Or could you please ask me again?

Q. Yeah. My question was, you received a

series of written materials electronically from counsel -- let's break it down.

You received a series of written materials electronically from the defendants' counsel in this case, correct?

A. Yes.

Q. After you received -- well, withdrawn.

Did all of those materials come to you in a single transmission?

A. I don't remember.

Q. Did they all come to you at or around the same time?

A. I don't remember.

Q. After you -- at any point during your involvement in this litigation, have you ever asked counsel for the defendants for additional information?

A. I don't recall whether I did or not.

Q. If you had asked counsel in this case for additional material, would you have done so by e-mail?

A. Not necessarily.

Q. Would it have been by text message?

A. That's a possibility. Or it could have

been by phone.

Q. In any event, to the extent that at any point you were provided with additional materials, you would have listed those materials in your report, right, as something that you had reviewed?

A. Not necessarily. If I had been provided additional materials and I did not review them for the report, I would not have listed them on the report.

Q. Any materials -- let's do it this way. Any materials that you reviewed in connection with the preparation for your report are listed in that report, correct?

A. That's not the most correct way to answer that question.

Q. Well, I'm not answering it; I'm asking it.

A. Well, it's not a yes-or-no answer.

Q. Did you review any materials in this case that form the basis of your opinion that are not listed in your report?

A. No.

Q. Your report indicates that you received and/or invoiced $14,000 in this case.

Dr. Murphy

Is that correct?

A. Yes.

Q. And that was for -- your report says that was for a preliminary review, "my review and analysis of the documents discussed herein, and the preparation of your -- of this report."

When you say your preliminary review in your report, what does that mean?

A. That means the first stages of my looking at the records.

Q. And when you say "the records," do you mean the documents that were transmitted to you electronically by defendants' counsel?

A. Yes.

Q. After "preliminary review" it says, "My review and analysis of the documents discussed herein." What does that mean?

A. That is my discussions with counsel regarding my findings.

Q. Your findings from your preliminary review?

A. That's not a yes-or-no answer.

Q. What's the answer then?

A. It includes all of my discussion with

counsel from all stages of my review, up until and the completion of my report that I submitted.

Q. How much time did you spend preparing the report?

A. I didn't keep track of an exact time, but it was probably around 50 hours. Something in that range.

Q. The 50 hours, does that encompass the review that preceded the actual preparation of the report?

A. Yes, I would say that would encompass a great portion of that time. I did not keep track of the exact number of hours.

Q. The $14,000, was that a flat fee that you were charging?

A. Yes.

Q. You're estimating about 50 hours for the preparation of the report. Do you have an estimate of the total amount of hours that you have spent up -- that you spent up to the completion of the report?

So according to your report, it would be your preliminary review, your review and analysis of the documents discussed in the report, and the

preparation.

Do you know what the total amount of time was for those tasks?

A. It was around 50 hours.

Q. Okay. Do you intend to charge for your time for appearing for this deposition?

A. Yes.

Q. Do you charge an hourly rate?

A. No.

Q. What do you charge?

A. $6,000 for the full day of deposition.

Q. Does that include your preparation for the deposition?

A. Yes.

Q. And how many hours did you spend preparing for the deposition?

A. Probably under two hours.

Q. And besides reviewing documents and speaking with counsel, did you do anything else in preparation for the deposition?

A. No.

Q. Did you do any research -- at any point during your involvement in this case, did you do any research on your own about the case?

Dr. Murphy

A. No. I have a pretty in-depth knowledge of the way these practices -- the way practices run, and pain practices and drug screens in general. So I did not have to do any in-depth or additional research other than review the records that I mentioned in my report.

Q. As I indicated in my initial remarks, this certainly is not your first time testifying under oath, correct?

A. Correct.

Q. You have, in the past several years, testified in a series of criminal cases.

Is that right?

A. Yes.

Q. And in those cases, you have testified in the capacity of a defense expert, right?

A. In almost all of those cases, that would be correct.

Q. Are there cases where you did not testify as a defense expert?

A. Yes.

Q. Which case or cases?

A. It wasn't a criminal case; it was a malpractice case. And I was on the plaintiff's side

of the equation. And it was not in defense of the healthcare team.

Q. When was that?

A. Within the last couple of years. I'm not sure exactly when that date was.

Q. As part of your report, you provided us with a list of the testimony you've given.

Withdrawn.

Would it be fair to say, Doctor, that many of the criminal cases in which you had testified have involved healthcare professionals who are accused of overprescribing opioids?

A. Yes.

Q. And in many of those cases, the issue of urine drugs testing has come up?

A. Yes.

Q. And in some of those cases, some of those doctors were alleged or accused to have not used urine drug screens frequently enough, right?

A. I don't remember the exact accusations of the cases.

Q. In any of the cases, the criminal cases that you testified in in the last four years, is the issue of urine drug screens being used too

infrequently by the accused physician been something that you have addressed?

A. I don't recall specifically.

Q. Do you -- have you ever issued opinions in a criminal case as an expert that -- defending infrequent use of drug screens?

A. I don't recall the specifics of any testimony like that.

Q. Generally speaking, have you ever given testimony in that -- with that general thrust?

A. I don't recall specifics of my previous testimonies.

Q. I'm stipulating that, Doctor. Generally speaking, do you recall -- as you sit here today -- let's do it this way.

As you sit here today, is it your testimony that you do not recall ever testifying to defend infrequent use of drug screens?

A. I don't recall what my -- the specifics of my testimonies.

Q. You testified in a case in Monroe County, New York, earlier this year.

Is that correct?

A. I'm not sure where Monroe County, New

Dr. Murphy

York, is.

Q. Have you ever testified in -- well, withdrawn.

This year, did you testify in state court in New York?

A. Yes.

Q. And that was a state level criminal case, right?

A. Yes.

Q. Do you know what the result of that case was?

A. No.

Q. You don't know if the doctor was -- or if there has been a result?

A. I have not been made aware of the result of that case at this point.

Q. Doctor, you are not a toxicologist, correct?

A. Correct.

Q. Do you have any formal training with regards to liquid chromatography-mass spectrometry testing?

A. Yes.

Q. What formal testing do you have with

LCMS?

A. I am a board-certified and fellowship-trained pain specialist in Mayo Clinic in Rochester, Minnesota. During my time there, as part of my education, I had to be familiar and be, essentially, well-versed on the different types of urine drug screens.

And the discussions and understanding, both liquid chromatography and gas chromatography was essential to my fellowship education.

Q. You have a pain practice of your own.

Is that right?

A. Yes.

Q. Your -- do you have one office or multiple offices?

A. I have one office.

Q. At your pain practice's office, do you have LCMS instrumentation?

A. No.

Q. At any point during your involvement in this case -- well, withdrawn.

As part of your involvement in this case, how many times did you speak to Dr. Zaitsev?

A. To my knowledge, I have never spoken to

the doctor.

Q. As part of your involvement in this case, how many times did you speak with Dr. Gorman?

A. To my knowledge, I have never spoken to Dr. Gorman.

Q. And certainly, you have never asked to speak with either Dr. Zaitsev or Dr. Gorman?

A. To my knowledge, I have never asked to speak to either of those doctors.

Q. Did you ever want to speak to them?

A. No.

Q. And nothing in your review of the materials that we have previously discussed at any point made you think that it would be best for you to have a discussion with either Dr. Zaitsev or Dr. Gorman?

A. No.

Q. In addition to your medical practice, you're also a -- you're a volunteer assistant clinical professor at the University of Louisville Medical School, right?

A. Yes.

Q. It's not a paid position, right?

A. Correct.

Dr. Murphy

Q. As part of your medical practice, it would be fair to say that you regularly prescribe controlled substances, narcotics and opioids?

A. Yes.

Q. The $14,000 that -- your report indicates you received and/or invoiced $14,000. Did you actually receive $14,000 yet?

A. To the best of my knowledge, yes. I have received that.

Q. And was that invoiced? In other words, is there an invoice somewhere with your name at the top of it that says $14,000 listed on it?

A. I'm not certain exactly what the documentation that was requested and what was sent.

Q. But certainly, there was some document that served as a formal request for $14,000?

A. That is my usual practice, to specifically ask for it. I don't know exactly what form that took in this case.

Q. Aside from the written documents, the written materials, I should say, that were electronically transmitted to you by the defendants' counsel, were you provided with any factual information by the defendant's counsel besides the

written documents?

A. Not to my knowledge.

Q. Were you asked to make any assumptions upon which your opinions would be based in this case?

A. Not to my knowledge.

Q. So then it would be fair to say, Doctor, that the opinions that are contained within your report are based entirely on your review of the written documentation inasmuch as -- and let me clarify the question. Inasmuch as the facts that you found to give rise to your opinions?

A. Yes. It's based upon the written documentation that I've outlined in my report.

Q. When you reviewed Geico's complaint, did you -- and based on that review, did you come to understand that Geico was making allegations concerning, among other things, the ownership of medical practices called Tri-State and Riverside?

A. I don't recall the specifics of what the Geico complaint said.

Q. And were the specifics of Geico's allegations in this case important to you in the context of forming your opinions in this case?

Dr. Murphy

A. Yes.

Q. And in what way were they important?

A. Well, Geico was bringing this action against these -- this group. So it's important to know how Geico feels that they were harmed and what the allegations are so that in my review, I'm addressing, to the best of my ability and within the context of my expertise, the concerns that Geico has.

Q. As part of your review of the materials in this case, you learned that there was a laboratory performing urine and drug testing that was one of the defendants in the lawsuit, right?

A. I know there is a lab that is doing, I guess, most of the drug screens. I'm not sure exactly who owns that or the nature of that.

Q. Okay. So that's a different question. You know -- my question is, you know that there's a lab who is one of the defendants in the case, right?

A. I don't have the complaint in front of me. I know that there's a lab involved in this. I don't recall whether they are one of the defendants. And I say that because I don't have the complaint in front of me.

Dr. Murphy

Q. So then you kind of asked my next question -- answered my next question, which is, do you have an understanding as to the ownership of that lab?

A. I don't have an understanding that I would say is -- that I relied upon or that was confirmed to be accurate.

Q. Okay. But I didn't ask you that. I asked you if you had an understanding as to the ownership of the lab.

A. Yes, an understanding.

Q. All right. And what was that understanding?

A. That a doctor or one of the providers -- one of the people at the clinic that was providing clinical care had -- at least had worked there at some point in time and now they were involved in the lab that's in question. In terms of the exact ownership and how that came about, I don't know the specifics of that.

Q. And again, the specifics of the ownership and affiliation of these entities and the affiliation of the various doctors with the entities, those things were immaterial to you in the

Dr. Murphy

context of forming your opinions?

A. Yes.

Q. As part of your review in this case, did you come across the name Dr. Sangavaram?

A. I don't recall.

Q. At any point during your involvement in this case, were you made aware that a Dr. Sangavaram was asked during his deposition whether the urine tests ordered through Tri-State and Riverside were medically necessary, and that he invoked the Fifth Amendment privilege against self-incrimination in response to those questions?

A. I'm not aware of that.

Q. Okay. Hearing me ask you that question, does that give you any cause for concern about this case and the opinions that you've offered?

A. No.

Q. If a doctor in this case was asked whether or not these urine screens were medically necessary and that doctor pleaded the Fifth Amendment in response to those questions, that would be something that would be immaterial to your opinions in this case?

Dr. Murphy

A. Yes.

Q. As part of your -- at any point during your involvement in this case, have you taken any notes as part of the preparation of the report, your review of the materials, or your preparation for this deposition?

A. I don't recall what notes I've taken, or if I've taken any that were not in the report.

Q. You don't recall. So what about this morning? Did you take any notes this morning before we signed on?

A. No.

Q. Yesterday, did you take any notes?

A. No.

Q. So one of the other things, categories and materials that you reviewed were the reports of Geico's experts, right?

A. Yes.

Q. And one of those reports was from a medical doctor, right?

A. I can't recall exactly the credentials of the experts.

Q. Okay. Do you know what kind of experts they are?

Dr. Murphy

A. I know that one was a toxicologist. And I don't recall the specific credentials of the other expert.

Q. Okay. The specific credentials. What about generally? What do you recall about the other expert?

A. Well, from my memory sitting here right now, I don't recall specifically the credentials or even the name right now of the other expert. But I've got it in my file and I can look at it or you can show it to me, but I don't recall right now the specifics.

Q. I believe you testified that in preparation for the deposition, that you reviewed these two Geico expert reports, right?

A. Yes.

Q. And you did that yesterday and this morning?

A. I definitely did it this morning. I'm not sure what I looked at yesterday. It might have been a couple of days ago I was looking at the expert reports.

But it was -- I definitely looked at something this morning and I do recall looking at

some reports last night. So yes, today and yesterday for sure. And I might have looked at some a couple of days ago.

Q. Okay. So you reviewed these materials multiple times in the last 24 hours. At any point during those reviews, did you take note of the credentials of either of Geico's experts?

A. Yes.

Q. Including this morning, you took note of the credentials of Geico's experts?

A. I looked at the heading at the end. I read that briefly.

Q. So that was only just a couple of hours ago, right?

A. Yeah, that was about 8:15 this morning.

Q. 8:15 of -- you're Central time?

A. I'm Eastern Time.

Q. Let's talk about the preparation of your report. Would you agree with me, Doctor, that as part of the preparation of your report, you copied and pasted the language of other people?

A. I don't know exactly where I got all the information in my report.

Q. I didn't ask you if you knew where you

got all the information from your report. My question was, would you agree with me that at least portions of your report were copied and pasted from articles written by other people?

A. To the best of my knowledge, it was not taken exactly, but there were some articles, there were some other reports that I borrowed language from.

Q. So would the answer to my question then be yes, at least portions of this report were copied and pasted from articles written from other people?

A. To the best of my knowledge, no.

Q. Okay. So then would your position be that you read articles written by other people and paraphrased their language?

A. Yes. Some of that language in the report is paraphrased from other sources that I've read.

Q. And when you were deciding to paraphrase language from other sources, some of those sources are, for lack of a better term, scholarly articles written by medical professionals?

A. Yes.

Q. And before you cite to and paraphrase

language from articles like that, do you read the entire article?

A. Not always.

Q. Do you read the entire sections of those articles that will be pertinent to the issues in front of you?

A. Not necessarily.

Q. So you're not concerned about what those articles say generally. You're just lifting and paraphrasing selections of those articles, correct?

A. No.

Q. So it is important to you what those articles say in the portions that you don't read?

A. No.

Q. It's not important. Okay. Who physically typed up your report?

A. It's on a computer that I use -- a Word processer, and it was entirely by me.

Q. It's dated March 20, 2023. Do you recall when it was actually -- well, withdrawn.

When you completed your report, did you transmit an electronic copy of it to the defendant's counsel?

A. Yes.

Q. If I wanted to speak not like a lawyer for a second, you e-mailed it to him?

A. Yes.

Q. Do you recall if that was on March 20th?

A. I believe it was. I have to look at the calendar to be sure. But I believe the date that I finished the report is the date that I e-mailed it to counsel.

Q. Prior to that date, had you ever transmitted unfinished or earlier versions of the report?

A. Yes.

Q. To defendant's counsel?

A. Yes.

Q. And once you've transmitted those earlier versions of the report to defendant's counsel, did you have any discussions with defendant's counsel about those versions?

A. Yes.

Q. Were those discussions ever in writing?

A. I don't recall them being in writing.

Q. Would it have been over the phone?

Dr. Murphy

A. It was over the phone. I sent at least one draft. And I don't recall specifically how we discussed, you know, the content, the final content. There definitely was a phone call. There may have been some writing, but I don't recall exactly how we worked on the -- what I would find, what I would submit as my final report.

Q. Were there -- in connection with this case, were there any issues that you refused or declined to opine on?

A. No, not that I was specifically asked about. I did say that my expertise is in the clinical aspect of it. And although I do understand the business aspects of medicine, that I would not be able to be an expert on the coding and billing, and that sort of aspect of it.

Q. So to be clear then, you are not in this case offering an opinion concerning the propriety of the billing submitted by the defendants inasmuch as the coding and the pricing is concerned?

A. I am not offering an opinion on the pricing. And I am not a coding expert. However, I do understand how this goes, how these practices are run, and how billing is done for drug screens of

Dr. Murphy

this nature. So I have an opinion. I am not an expert, however, in coding and billing for drug screens.

Q. Are you -- I understand that you're not an expert in coding or drug screens. By extension, Doctor, you are not here offering an opinion concerning the coding in this case, correct?

A. Correct.

Q. Okay.

MR. CONROY: Hey, Steve, can we take five minutes? I just want to take five minutes and get a refill.

MR. HENESY: Of course. Five minutes.

(Whereupon, a recess from 11:03 a.m. to 11:11 a.m. was taken.)

MR. HENESY: Ariella, can you read back the last exchange?

(Whereupon, the referred-to question and answer was read back by the Reporter.)

MR. HENESY: So we're going to now mark the first exhibit.

(Whereupon, Plaintiff's Exhibit 1, Expert disclosure document and Dr. Murphy's report, was marked for identification as of this date by the

Reporter.)

BY MR. HENESY:

Q. I've marked as Exhibit 1 a 21-page PDF which I will represent is the expert disclosure document provided by the defendant's counsel, attaching as an exhibit Dr. Murphy's report which goes from Page 4, with the attachments to Page 1. We're going to start on Page 4. Let's start there.

Doctor, can you see that?

A. Yes.

Q. Is it large enough that you can read it?

A. Yes.

Q. If at any point -- I have the ability to zoom here, so at any point you're looking at something and you need me to zoom in, don't hesitate to ask, and I'd be happy to do so.

A. I can actually zoom on my end. If you see my hand coming up, I'm zooming in.

Q. Okay. So certainly, this is the first page of your report, right?

A. Yes.

Q. And I want to go -- I want to start on Page 2. I'm going to start -- I'll zoom in -- to

Dr. Murphy

the top paragraph starting with -- I'll highlight it there, "In sum." Can you see that?

A. Yes.

Q. And I'll read it for the purposes of the record. It says, "In sum, the defendants' policies, procedures, and utilization of drug screens in caring for their patients were reasonable, medically necessary, in the usual course of professional practice, for a legitimate medical purpose, and consistent with the applicable standard of care."

Did I read that correctly?

A. Yes.

Q. So my first question for you Doctor, is, when you refer to policies and procedures and utilization of drug screens, in your own words, Doctor, what are the policies, procedures, and utilization of drug screens that you're referring to in that sentence?

A. That is how our practice approached drug screens and how they generally did it as a policy across the board.

Q. Okay. Right. So what was the policy that you're referring to?

Dr. Murphy

A. The practice of general screening and doing drug screens on most of the patients that came in in a universal precautions sort of approach, and getting both a large number of presumptive testing, the screening examination, and then a -- going onto the definitive testing in what appeared to be most of the cases.

Q. Okay. When you say "most of the cases," what does that mean? Because most could be 51 percent, right? So what does most mean to you?

A. In the records that I reviewed, and in the context of the other materials that I read, including what the experts had said from Geico, it appeared that a large number -- and I don't know the exact percentage -- but almost all of them went on to the definitive testing, from my understanding.

Q. So when -- to be clear then, when you refer to the defendants' policies and procedures, what you're referring to is your perception that the defendants had a policy of utilizing presumptive and definitive drug testing on almost every patient?

A. Yes.

Q. Are you aware or were you made aware of any formal written policies to that effect generated

in connection with the defendants' testing?

A. I don't recall seeing any of those.

Q. As you sit here, Doctor, do you know or were you made aware of who it was that instituted the policy or procedure that you just referred to?

A. No.

Q. So when you say -- you go on to say that the policies, procedures, and utilization of drug screens were medically necessary, what is your definition of medically necessary, Doctor?

A. The definition that I use is that the patient has a medical issue, and then the treatment or test, in this instance, is in order to benefit and help the patient get well.

So if the patient has a medical need and the treatment or procedure or test is designed to benefit that patient to get well, then it is satisfying a medical necessity.

Q. Using that definition where the procedure or testing is provided in order to or designed to help the patient, is the subjective intent of the healthcare provider relevant to you?

A. Yes.

Q. And so by saying that these services

were medically necessary, using your definition, are you opining, Doctor, that it was the intent of the defendants in this case to help their patients?

A. I cannot comment on the intent, because I can't get in their brains and know what they're thinking. But I can comment on the behavior that I review and tell you that in my experience it's consistent with what I've seen and what I've experienced when physicians are trying to help their patients.

Q. Certainly, if the subjective intent was a component of your definition of medical necessity, would you agree that it would have made sense then to ask Dr. Zaitsev or Dr. Gorman or any of the other healthcare practitioners in this case what their intent was in order to reach your opinion?

A. I can't answer your question because you asked me a question that was -- is incorrect from the beginning. Your premise is incorrect.

Q. Why is my premise incorrect?

A. Because I did not base my opinion on the physicians. I based my opinion on the records that I reviewed and the behaviors that I saw. And so it was consistent with what I had come to

understand with is the behavior of physicians trying to help their patients, with the intent to help their patients so --

Q. So let me ask it a different way, Doctor. Do you think it would have been different to hear it from the horse's mouth?

A. I don't know.

Q. You can't say whether or not it would have been helpful to identify the subjective intent of the healthcare practitioners in this case by asking the healthcare practitioners in this case what their subjective intent was?

A. As a review -- or looking at the facts in this case as were presented to me, the subjective intent is possibly helpful, but not necessarily. So -- and it can also be if the physician doesn't understand a question properly, it can also detract from what the truth factually is. So it could be helpful. It's not always helpful. It wasn't necessary for me in this case.

Q. Because you could tell what their subjective intent was from their behavior?

A. No, I could not. What I said was the behavior is consistent with what I understand to be

beneficial to patients. What I have seen in other physicians in my experience as being activities and actions that are intending to benefit patients. I don't know what was in the doctors' heads who were prescribing these treatments and these tests.

Q. So when you reviewed the materials in this case, Doctor, you -- and as you have now testified that the defendants in this case routinely conducted both a presumptive and confirmatory urine drug test on virtually every patient, right?

A. In my understanding, it's that it was almost all of the patients. That was correct. But not every patient.

Q. Okay. As part of your review, did you see any document that would suggest that it was not every patient?

A. I think in the expert -- one of the expert reports that I read, there was mention that it was not every patient.

Q. So you're accepting that as true for the purposes of your own opinion?

A. No, but I took that into consideration.

Q. So you're not accepting that as true, then? You have some reason to doubt that?

Dr. Murphy

A. Yes.

Q. What is your reason to doubt that?

A. Because people make mistakes and your expert -- the Geico expert could have made a mistake.

Q. But you don't have any actual evidence that they made a mistake, right?

A. No.

Q. Okay. And of the patient files that you specifically reviewed, did they all get urine drug tests, both definitive and presumptive?

A. I don't recall the specifics of the -- all the cases that I reviewed.

Q. Okay. You also say that your opinion is that -- you say that your opinion is that the urine drug tests were provided for a legitimate medical purpose. Is that your opinion?

A. Yes.

Q. What was the legitimate medical purpose for which the urine drug tests in this case were administered?

A. Well, first and foremost, to provide therapeutic benefit to the patient. And these were patients that had pain. And a lot of the

medications that you would discover in a drug screen can impact the care of patients. So they were gathering information that would help them in decision making going forward in caring for these patients.

Q. When you say that they were gathering information to assist in their decision making going forward, did anybody tell you that's why they were doing the urine drug screens?

A. I don't recall that.

Q. Did you see in any document it said that the urine drug screen was being ordered for the purpose of assisting medical decision making?

A. I don't recall that.

Q. Did you see in any document that there was any justification at all given for why the urine drug screen was being ordered?

A. There are requisition forms that sometimes people can document the medical necessity and the reason for them. I don't -- and I know I looked at some of them, maybe a lot of them. I don't recall an exact number, but I don't remember specifically what was written on those lines or if it was written elsewhere.

Dr. Murphy

Q. My question to you, Doctor, was, did you see any written documentation as part of your review in this case setting forth a specific justification for the ordering of a urine drug screen?

A. Yes.

Q. You did. What did it say?

A. That the patients had pain. They were seeking pain care. And that is one of the most common things that pain clinics do, is drug screen their patients. And that's the reason why we do it. So it's -- that's the specific reason. They were seeking pain care.

Q. But you are assuming that as the reason. Isn't that right, Doctor?

A. Yes.

Q. This opinion that's listed at the top of Page 2 where you say, "In sum, the defendants' policies, procedures, and utilization of drug screens in caring for their patients were reasonable, medically necessary, in the usual course of professional practice, for a legitimate medical purpose, and consistent with the applicable standard of care." Which patients are you talking about

where you reach that opinion?

A. Every patient that I reviewed and every instance that I saw applies to that statement.

Q. Okay. So if we then go back up -- excuse me, to Page 4, to materials reviewed. Okay. In materials reviewed, it says, "From counsel, I was provided files containing medical records, prescription data, and other items related to patients of the defendants with the initials WV, IE, MR, SA."

Did I read that correctly?

A. Yes.

Q. Okay. So there were four patient initials listed here, right?

A. Yes.

Q. Are you offering an opinion concerning the propriety of the testing in this case concerning those four patients?

A. Yes.

Q. Are you offering an opinion concerning the propriety of the testing with regard to any other patients besides those four?

A. Yes.

Q. Which patients are you offering an

opinion about?

A. I can't tell you specifically because I don't know. But there are -- there was multiple mentions of drug screens in the records that I reviewed. So I'm making a general statement about a large population of patients.

I'm pointing out those four patients because I was specifically given items that relate directly to those four patients as examples. And that's why I mentioned those, because those are four examples of patients that typify, in my opinion, how late drug screens were utilized by this clinic.

Q. What are you basing that opinion on, that those four files typify how this lab did its testing?

A. Well, the materials that I received. And as I mention in my report what I reviewed, that includes the expert reports from the Geico experts. And they talk about the practice in general and things of that nature. So in looking at the records in total, I was able to draw a conclusion that I believe is applicable to the entire practice.

Q. Okay. So this -- the answer to my question then is you are here offering an opinion in

this case concerning every patient that received drug testing from the lab in this case?

A. No.

Q. Okay. I'll ask you again then. Which are the patients about whom you are offering an opinion?

A. Specifically, those four patients right there. And then generally, the majority of patients that would attend the clinic, but not -- I cannot generalize my comment to specifically include every single patient that attends that clinic.

Q. Okay. Which clinic are you talking about?

A. The pain clinic that treats -- treating the patient.

Q. Do you know -- what's the name of the pain clinic that you're referring to?

A. It's probably in the report somewhere. It's certainly in the complaint, but I don't have it in front of me. I have -- I'm looking at right now what you're giving me, which is like a paragraph. I can't see the page number, so -- but it's been provided and it's in the -- clearly, it's in the complaint. So it's documented. And I'll be glad to

look at it if you show it to me as well.

Q. The complaint has nothing to do, Doctor -- our complaint, Geico's complaint, has nothing to do with the universe of patients about which you are offering an opinion. So I need a specific answer to this question.

So do I understand your testimony correctly that you are offering an opinion about the majority of the patients that were treated at a pain clinic, the name of which you do not know?

A. Yes.

Q. Okay. And when you say majority, do you mean 51 percent? Do you mean 80 percent? What does a majority mean?

A. I think almost all of the patients.

Q. Okay.

A. I am not --

Q. So you are --

A. I can't remember.

Q. You are here to offer an opinion concerning almost all of the patients at issue in this litigation. Is that what you're saying?

A. No.

Q. What are you saying?

Dr. Murphy

A. I'm offering an opinion based on the practices of the drug screening and again, the medical necessity of this practice. And my opinions would be related to the majority of the patients that the practice saw.

Because my understanding, from reviewing the records and the expert reports, is that this was the general policy of how they approached their patients. Therefore, my opinion, based upon the entirety of the circumstances, is applicable to the practice as a whole, and from what I perceive to be, and what my assumption is, the majority of patients that went there.

Q. So if I understand your testimony correctly, Doctor, based on your review of the four files, the initials which are listed in your report, and the expert reports for Geico's expert, based on your review of those materials, you believe you can then extrapolate your opinion that you've reached to almost all of the patients treated at the clinic whose name you do not know?

A. No.

Q. What did I get wrong?

A. I -- my opinion is based upon

Dr. Murphy

everything I mentioned in my report. So it's more than what you just said.

Q. Okay. So it's based upon your review of the complaint, the four files that you were provided with, the transcripts of two doctors.

Anything else?

A. Okay. I was reading my paragraph again. Would you ask me the question again, please?

Q. Yeah, sure.

MR. HENESY: Would you mind reading back the question for me, please? Thank you.

(Whereupon, the referred-to question was read back by the Reporter.)

BY MR. HENESY:

Q. I'll add to the question, the expert reports, Geico's expert reports.

A. Okay. So the answer is, in addition to what you just mentioned, also the complaint, the amended complaint, as I indicated there. And I also -- I list a cite of references as included in my report. So I base my opinions on references in my report as well.

Q. But factually, those listed references did not influence your opinion, correct?

Dr. Murphy

A. No, they did.

Q. The listed references added additional facts upon which you based your opinion?

A. Of course they did, yes.

Q. What facts did your listed references add?

A. They informed me medically about how to view the practice of medicine that was being done by the defendants. So that information does matter in terms of my opinion.

Q. I'm going to stay on Page 4 now and I'm going to highlight this sentence here, the last sentence of this paragraph. It's the second-to-last paragraph in Page 4. And it begins, "The defendants use of drug testing (UDT) was clearly aimed at providing therapeutic benefit to their patients."

Did I read that correctly?

A. Yes.

Q. And is that your opinion?

A. Yes.

Q. And again, when you say that the use of the UDT was clearly aimed at providing therapeutic benefit to their patients, you mean almost all of the patients at the pain clinic, right?

Dr. Murphy

A. Yes.

Q. Do you believe, Doctor, that it's important that urine drug testing must be ordered by a qualified healthcare professional, correct?

A. No.

Q. You don't believe that it's important that urine drug testing be ordered by a qualified healthcare professional?

A. I think to get paid, sometimes they require that.

Q. Okay. But you don't think from just your medical necessity perspective that it would be important in the context -- and let me narrow it.

In the context of a pain management practice, do you think it's important that a drug test be ordered by a qualified healthcare professional?

A. I think that is important.

Q. And because, ultimately, it will be the doctor's decision on what's medically necessary for the patient, right?

A. Not necessarily.

Q. It would be the doctor or another qualified healthcare professional's decision on what

is medically necessary for the patient, right?

A. Not necessarily.

Q. So an unqualified person can make a determination of a medical necessity of a urine drug screen, in your opinion?

A. Not necessarily.

Q. Well, if it's not necessarily for either then, isn't it the doctor who decides how frequently the tests should be given?

A. Not necessarily.

Q. Well, can the owner of the lab make the decision about the medical necessity of a urine drug screen?

A. I do not consider the opinion of the owner of a lab a medical necessity.

Q. So I'm a lawyer. Would you consider my opinion?

A. Would I consider your opinion? It depends.

Q. Well, assume for the purposes of this discussion that I am a lawyer and only a lawyer, and I am not a qualified healthcare practitioner. Would you take my -- would you find my opinion to be persuasive?

Dr. Murphy

A. It -- that would depend.

Q. On what?

A. On whether you have a valid argument and can present facts that would be -- that would support the medical necessity of a test.

Q. And my licensure or lack of licensure or qualifications as a healthcare professional would be irrelevant?

A. No, it would be relevant.

Q. In this case, Doctor, did you see any evidence that the urine drug screens were being ordered by someone other than a licensed healthcare professional?

A. I did not see -- I do not recall seeing any evidence that they were ordered by other than a licensed healthcare professional.

Q. Do you recall reading any testimony concerning -- well, withdrawn.

Do you recall Dr. Gorman giving testimony concerning his signature of the lab requisition forms?

A. I read his testimony. I don't recall the specifics about that as I sit here right now.

Q. Do you recall Dr. Gorman testifying

Dr. Murphy

that if a lab referral doesn't have his signature on it, then he didn't order it?

A. I don't recall that testimony specifically.

Q. Sure. Let's see if we can refresh your recollection.

MR. HENESY: This is Exhibit 2, which is Dr. Gorman's deposition transcript. It's a 239-page PDF.

(Whereupon, Plaintiff's Exhibit 2, Dr. Gorman's deposition transcript, was marked for identification as of this date by the Reporter.)

BY MR. HENESY:

Q. I'm going to go to Page 42. On Page 42, I'm on Line 14.

"QUESTION: Just so that I understand your testimony, if a lab referral doesn't have your signature on it, you would deem that to be unauthorized?

"ANSWER: If a lab referral doesn't have my signature, then I didn't order it.

"QUESTION: Even if at the top of the referral, it has your name on it?

"ANSWER: No. Prescriptions have to be

signed."

Did I read that correctly, Doctor?

A. I think so.

Q. And do you recall reading that testimony when you reviewed this transcript?

A. I read the transcript. I don't remember the details that I read as I sit here right now.

Q. What's described in that testimony there -- a lab referral form that doesn't have a signature even if it has Dr. Gorman's name on top -- did you see any instances of that in the records that you reviewed?

A. I don't remember the specifics of the records that I reviewed and what was on the forms. I'd be glad to look at some if you want to show me, but I don't recall the records that I reviewed in specificity.

Q. If there were instances of unauthorized urine drug screens being performed by the lab in this case, would that have influenced your opinion at all in this case?

A. I have to know what the word "unauthorized" means.

Dr. Murphy

Q. Not ordered by the doctor.

A. Again, I -- a lot of times, there are standing orders and policies that practices will do, and it's -- it can be done for medical necessity in the best interest of the patient and in a therapeutic manner, and the doctors don't sign those. And that's still --

Q. Right. But a standing order, Doctor, would be authorized, wouldn't it?

A. Not always -- oh, authorized? A standing order would be -- I would consider that authorized.

Q. Okay. I'm not talking about authorized. I'm talking about unauthorized. If you had evidence that there were unauthorized urine drug screens being tested, being performed by the lab, unauthorized, not authorized by the doctor, would that have influenced your decision -- withdrawn -- influenced your opinion in this case?

A. Again, I'm not sure what you mean by "unauthorized."

Q. Not ordered by the doctor. Not authorized by the doctor.

A. Not necessarily.

Dr. Murphy

Q. That wouldn't matter to you?

A. It would matter.

Q. But it wouldn't influence your opinion?

A. Perhaps.

Q. So in what way would it matter?

A. Well, I have to understand what the doctor meant by didn't sign. Sometimes doctors don't understand that -- you know, that labs are things that we do on a regular basis, get it done, by the clinic in its policy. And it's done in a universal precautions manner. And it ends up being medically necessary and in the patient's best interest.

And whether or not the doctor signed the requisition or not, that may have some bearing on whether the lab ultimately will pay for it. It doesn't necessarily have bearing on whether it was an appropriate test ordered or whether it was actually in the patient's best interest.

Q. I'm not asking you about signed versus unsigned. Okay. You're drawing a distinction in that answer between signed and unsigned. I'm -- and by the way, for the record, I removed the exhibit from the screen.

Dr. Murphy

I'm drawing a distinction in my question, Doctor, between authorized and unauthorized. Sanctioned by the doctor and unsanctioned by the doctor.

MR. CONROY: Objection as to form.

MR. HENESY: Okay.

BY MR. HENESY:

Q. You can answer it. With that clarification then, Doctor, not signed [sic] versus unsigned. I'm talking authorized versus unauthorized. Would that have been something that would be important to you if that were the case here?

A. It depends.

Q. So not necessarily, that would be important?

A. I've answered it depends.

Q. Okay. What would it depend on, Doctor?

A. Whether or not that the clinic as a whole, which is to take care of patients, whether or not that was their usual and customary practices to order those drug screens. And whether or not the drug screens were ordered in effort to benefit the patient and -- who has a medical problem.

Dr. Murphy

Then that would be a -- whether or not the doctor signed that requisition. A signature on a form is not a patient. A signature on a form is simply a piece of paper. And we treat people, we treat people that have diseases, that have medical needs.

We don't treat forms or requisitions, but I understand that that's important to get paid and it's important for documentation for legal reasons.

But what you're asking me about whether or not it would be okay to do a test on somebody because it's the usual course of the practice, even if the doctor forgot to sign it or didn't sign it for some reason, yeah, it could certainly be reasonable and appropriate for a test to be done.

Q. I'm not talking -- and I'm going to repeat myself, Doctor. I understand your position, that from a paperwork perspective, signed versus unsigned may not have a material effect.

I'm talking about an unauthorized test, a test that is not pursuant to a standing order and is not authorized by the doctor. Assume those two facts for the purposes of my questions, the doctor

didn't order it and there was no standing order. Assume those two facts.

If those two facts were true in this case, would a bunch of blank prescription forms that didn't have signatures on them, and with that testimony from Dr. Gorman that if he didn't sign it, he didn't order it, would that have influenced your opinion in this case?

A. Your question is not an accurate question. I can't answer it the way you asked it. It's -- it doesn't make sense.

Q. Okay. You can't answer the question on whether or not that would be appropriate or if it would influence your decision. Okay.

A. I can't -- I can't answer the question in the way you asked it because it was a nonsensical sort of question. It didn't make sense.

Q. Okay. Let's go back to your report on Page 2. At the bottom of Page 2, there's a sentence that begins, "I continue to practice full time." It says, "I continue to practice full time, and, like the defendants in this case, I utilize drug screening as a risk mitigation strategy in caring for my patients."

Dr. Murphy

Did I read that correctly?

A. Yes.

Q. Does -- that seems to suggest to me, Doctor, that it is your belief that the defendants in this case were using the drug screens as a risk mitigation strategy. Is that your opinion?

A. Yes.

Q. And of course, there is no document in this case that you reviewed that specifically says that the urine drug screen was being ordered as a risk mitigation strategy, right?

A. I don't recall.

Q. Okay. You're assuming that it was a risk mitigation strategy?

A. I may have read it somewhere. There's a lot of documents. I don't recall right now exactly what -- the specifics of what I read.

Q. So my -- so the question before you, Doctor, is -- or the question I'm asking you now is, when you say that the defendants were using the urine drug screens as a risk mitigation strategy, was that based on something you read, or are you just assuming that's why they were doing it?

A. I don't recall.

Dr. Murphy

Q. Okay. On Page 4, it says on the last paragraph, the first sentence says, "Our nation's expanding overdose crisis mandates increased caution when prescribing controlled substances for pain or any other condition." Do you see that?

A. Yes.

Q. In the records that you reviewed in this case, were any of the patients prescribed a controlled substance?

A. I don't recall specifically. There may have been, but I -- sitting here right now, I can't tell you specifically if -- if or who was.

Q. In the records that you reviewed, were any of the patients -- was there a notation that a controlled substance prescription was being considered for any of the patients?

A. I don't recall the specifics of what I reviewed right now.

Q. But in order to include -- the reason -- well, withdrawn.

Was the reason that this sentence was included in your report about the nation's expanding overdose crisis and the prescription of controlled substances is that you believe that a pain

management practice that utilizes the prescription of controlled substances might have more of a justification for ordering urine drug screens like the defendants did?

A. No.

Q. That's not why you included it there?

A. Correct.

Q. Did you include -- so I guess, what does that have to do with this case? "Our nation's expanding overdose crisis mandates increased caution when prescribing controlled substances for pain..." How is that relevant to this case?

A. Overdose is a tragic outcome sometimes to people that have chronic pain, and many people have pain that's not well-controlled by the non-controlled substances or procedures or things of that nature, and they will then either misuse their medications or get medications from the street. And sometimes the medications from the street can be tainted with fentanyl or other substances, and they can harm themselves or die.

And any patient who presents that has chronic pain is at risk for, at some point -- even if maybe at the presentation, but they're at risk

for being exposed to opioids or other controlled substances or even illicit drugs.

They're just -- it's a risk. It's like when somebody has diabetes. I mean, they come to see your office, they may be stable at that point, but there is a risk at some point that their disease could get out of hand and they could be in crisis.

So it's important that any time you're dealing with somebody with chronic pain or with acute pain, pain of any nature, that as much information as we can learn about the patient, it can be beneficial in treating them, even if I'm not the one prescribing the controlled substance, because I might in the future do it, or some other doctor who is getting my reports could see the records from my office and use my reports in the care going forward.

So yes, it's important that we consider the necessity of the use of drug screens for any patient that has chronic pain. And basically, the office seeing the patient can utilize those drug screens in the manner that they feel is the best for their patients.

Q. Okay. But this sentence says "when

Dr. Murphy

prescribing controlled substances." As you sit here today, Doctor, increased -- it says, "Increased caution when prescribing controlled substances."

As you sit here today, Doctor, do you have any knowledge of whether or not the pain practice at issue in this case ever prescribed a controlled substance?

A. I don't have any specific knowledge right now, as I sit here right now.

Q. Let's go to Page 5 -- Page 6, excuse me. At the top of Page 6, there's a sentence that starts "Ideally, clinicians..."

And it says, "Ideally, clinicians would only test for substances for which results could affect pain management; however, it can be challenging for clinicians in many settings to tailor widely used toxicology panels to include the specific substances most relevant to clinical decisions for their patient."

Do you see that?

A. Yes.

Q. Okay. There is no evidence that you're aware of in this case that it was challenging for the clinicians in this case to tailor the toxicology

panels to just those substances that would be most relevant to the clinical decisions, correct?

A. It's always challenging.

Q. Okay. So it's never not challenging?

A. It's always challenging.

Q. This says it can be challenging, right? So do you want to amend that to say it is always challenging?

A. It can be challenging is a correct statement.

Q. Okay. So it can be challenging. It is not necessarily challenging?

A. I just said it is always challenging.

Q. Okay. But that's not what your report says, so I'm trying to square what you're saying to me now versus what's in your report. Your report says it can be challenging. Now you're saying --

MR. CONROY: Objection as to form.

BY MR. HENESY:

Q. Sure. Now you're saying it's always challenging. Which is it, Doctor? Is it always challenging or it can be challenging?

A. They are both correct statements.

Q. Okay. So in your mind, those two

Dr. Murphy

statements, do they mean the same thing?

A. No.

Q. Okay. They are two statements that mean something different from one another. They're both true?

A. Yes.

Q. Okay. I understand that you believe it is always challenging for clinicians -- notwithstanding what your report says, you believe that it is always challenging for clinicians to tailor toxicology panels to the specific substances most relevant to the clinical decisions.

Did you see any specific evidence in this case that that was a challenge that the practitioners faced?

A. Yes.

Q. What specific evidence did you see that that was a challenge the practitioners in this case faced?

A. Patient had pain.

Q. Okay. So any patient that has pain -- if a patient has pain, it's automatically going to be challenging for the clinician to tailor the toxicology panel?

Dr. Murphy

A. Yes.

Q. Let's take that off the screen. So we're back to Exhibit 1, the report. The rest of this paragraph reads, "Toxicology testing costs are not always covered fully by insurance and can be a burden for patients, and clinician time is needed to interpret, confirm, and communicate results."

So I'm now going to show you Exhibit 3 -- the end of that paragraph, by the way, there's a reference to CDC 22, which is the 2022 guidelines that were put out by the CDC, right?

A. I list what that means at the end of my report, so you would have to look at that.

Q. Sure. Why don't we do that. We're on Page 15 of the report. CDC 22 is listed under references as CDC Clinical Practice Guidelines for Prescribing Opioids for Pain - United States 2022, correct?

A. Yes.

Q. Okay. So I'll take that off.

MR. HENESY: And now we're going to go to what's going to be marked as Exhibit 3.

(Whereupon, Plaintiff's Exhibit 3, CDC Clinical Practice Guideline for Prescribing Opioid

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for Pain - United States, 2022, was marked for identification as of this date by the Reporter.)

BY MR. HENESY:

Q. Okay. I've marked as Exhibit 3 a 100-page PDF. The first page says "CDC Clinical Practice Guidelines for Prescribing Opioids for Pain - United States, 2022."

Doctor, is this the report that you were citing to in your own report?

A. Yes.

Q. Okay. I want to go to Page 53. And I'll zoom in on the right-hand side where it says, "However, it can be challenging for clinicians in many settings to tailor widely used toxicology panels to include the specific substances most relevant to clinical decisions for their patient.

"Toxicology testing costs are not always covered fully by insurance and can be a burden for patients, and clinician time is needed to interpret, confirm, and communicate results."

Do you see that?

A. Yes.

Q. Okay. So this is language you cut and pasted out of the CDC guidelines into your own

Dr. Murphy

report, right?

MR. CONROY: Objection.

A. I'm not sure how I put it in there. But I -- I do like the way it was worded so I wanted to use that. I'm not sure how it ended up in my report.

Q. Okay. But if we go back to your report, and we go down to where you cite to this on Page 6, you have to agree with me, Doctor, that it's word for word what's in your report versus what's in the CDC guidelines?

A. I have to see it side by side. And if it is, that's why I referenced it.

Q. Okay. Let's do it side by side. Okay. So on the screen now, we have side by side, Exhibit 1, Page 6 of the report, and Page 53 of the CDC 22 guidelines.

Compare those two and tell me when you're done, please.

A. I don't see the CDC guideline.

Q. Oh, you're right. Did I not share two screens at once? How about now?

A. Yes.

Q. Okay.

Dr. Murphy

A. Yes.

Q. They're identical, right?

A. Yes.

Q. Okay. So this isn't paraphrasing, right? This is you just using the exact language from the CDC guidelines and putting it in your own report, right?

A. I clearly used the exact language in the CDC report.

Q. Right, okay. And you would agree with me that that wouldn't be paraphrasing, right?

A. Correct.

Q. Okay. Besides that language that you used word for word from the CDC guidelines, do you generally consider -- the 2022 CDC guidelines that we just had up on the screen, do you generally consider them an authority in the field of pain management?

A. Yes.

Q. And do you agree with the CDC guidelines?

A. Not in everything.

Q. Okay. And certainly, there are portions of -- you would -- I assume that you would

agree with me, Doctor, that there are portions of the CDC guidelines which contravene some of the opinions contained in your report in this case, right?

A. I don't think so.

Q. Would you agree with me that there are portions of the 2022 CDC guidelines that are inconsistent with what you're saying in your report in this case?

A. Not really.

Q. Is it your opinion -- in connection with this case, is it your opinion that the defendants' ordering of both a presumptive and definitive drug screen on almost every patient was entirely appropriate?

A. Yes.

Q. Based on your review of the records in this case, did you come to an understanding as to the timing of the defendants' presumptive and definitive testing and the results of those tests? And when I say the "timing," I mean the timing in relation to one another, each test.

A. My understanding is that for the most part, they were ordered at the same time.

Dr. Murphy

Q. And what about the results? What is your understanding concerning the timing of the results of the tests and the report generated that is communicating the results of those tests?

A. Okay. Two parts to that question. Presumptive results almost always come back or are available quicker than the definitive results. So it would be expected, and it -- I assume that presumptive results were done and were available sooner than the definitive results.

Q. What are you basing that assumption on?

A. The way that the labs operate. The way the tests are done.

Q. The tests in this case?

A. In every case. That's the way -- presumptive tests are done with a technology that is faster and less precise. And the specimens and the time it takes to do the definitive testing is longer.

Q. Did you see any evidence in this case that a separate report was generated in connection with the IA presumptive screening?

A. I don't recall any right now. There may have been, but I don't recall any.

Dr. Murphy

Q. Isn't it true that the reports that were generated by the lab in this case recorded the results of both the IA screen and the confirmatory test in a single report?

A. I don't recall. But that wouldn't surprise me if that was the case.

Q. Do you think, in your opinion as a general matter, Doctor, that the results of an IA ought to be reviewed before a confirmatory test is run? And when I say "reviewed," I mean reviewed by the ordering practitioner.

A. Not necessarily.

Q. So you think the inverse of that? You think it is entirely appropriate to run an IA screen, and before the results of that IA screen are communicated to the ordering physician, the confirmatory test in the same sample is run?

A. It can be.

Q. Do you think that is always appropriate?

A. No.

Q. Okay. What are the circumstances in which that would not be appropriate?

A. Depending on individual circumstances

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of the patient. And I can give an example: If a patient could not afford to have the definitive tests run, because they can be quite expensive, then it would be -- it could possibly be inappropriate to go ahead and send it for the definitive treatment in that case, because the benefit might not outweigh the harm to that patient. And by "harm," I mean financial harm of the patient.

So you have to take into consideration, who's paying for the test, whether it's the patient and whether that can be a hardship, or whether it's a third-party payer where it's going to be covered.

Q. So in your opinion, to the extent that a third-party payer is going to be responsible for paying for the drug screens, it is never inappropriate to order and simultaneously report an IA and LCMS test on the same sample?

A. Correct.

Q. And you say as much in your report, right? In your report -- let me go back to it. It's Exhibit 1. I'm now on Page 6 of the report. There's a sentence, the last full paragraph on the paragraph.

The last sentence says, "Thus, it is

never wrong to send a presumptive screening test on to the lab for definitive confirmatory testing - assuming cost to the patient is not a barrier that merits consideration, which it would not be in the No-Fault setting."

Did I read that correctly?

A. Yes.

Q. So when you say that it would not be in the No-Fault setting, what do you mean by that?

A. That means that the cost is not going to come back on the patient. It's covered. And therefore, the potential harm or the financial harm would not be something that would overcome the potential benefits.

Q. What is your level of familiarity with No-Fault insurance benefits in the state of New York?

A. My understanding is what I was told by counsel, is that there is a sum of money and it can go toward healthcare costs in the event of an accident, and it can include the drug screens. That's certainly healthcare. So it would fall under the category of No-Fault insurance. It would be covered after an auto accident in the state of New

York.

Q. Okay. You say a "sum of money." Were you told what the sum of money is?

A. A number was given to me.

Q. What is it?

A. I can't recall.

Q. Okay. Do you recall how much the defendants in this case were charging for a single instance of an IA and LCMS screen? In other words, the combined report that had an IA and the LCMS results on it, what that test was -- what was being charged for that test?

A. No.

Q. If I told you it was in excess of $4,000, would that refresh your recollection?

A. I don't remember being told what it was, the cost was.

Q. Okay. Does $4,000 strike you as high for that kind of testing?

A. It depends on the extent of the testing. Different labs charge different amounts.

Q. All right. But the extent of the testing in this case, you are familiar with, considering you reviewed the records in this case.

Dr. Murphy

So given the scope of the testing in this case, does $4,000 based on your experience strike you as high?

A. I don't know what the average or what would constitute a high charge for that type of test in this industry. It's going to vary from lab to lab and from place to place.

Q. Let's go back to Exhibit 3. Exhibit 3 is the CDC guidelines that we have been reviewing. I'm going to Page -- sorry, one second. I've been using the PDF numbers for Exhibit 3 rather than the page numbers at the bottom of the form, so I'm going to continue to do that for purposes of clarity.

We're on Page 87 of the PDF AB5 of the report. In the CDC guidelines here, do you see the highlighted sentence that says, "One study estimates the costs of urine toxicology testing (including screening and confirmatory tests) at $211 to $363 per test."

Do you see that?

A. Yes.

Q. And certainly, you -- would it be fair to say, Doctor, that you've read the CDC guidelines from front to back?

A. No.

Dr. Murphy

Q. Oh, you haven't?

A. I have not read every word in the guideline, no.

Q. It's not important for you to read them?

A. It can be.

Q. Okay. But it's not important for you to read every word in these guidelines?

A. It depends.

Q. Well, it either it is or it isn't. I'm talking about every word.

Withdrawn.

Okay. So now that you see that the CDC is -- you don't have any reason to doubt, by the way, what the CDC is saying here about the estimated cost of urine toxicology testing?

A. Oh, I have reason to doubt that.

Q. You do. What is the reason upon which you are basing your reason to doubt this?

A. Well, I would have to look at 74, what that means. That's a reference to an article. I would have to go to the article and see what that article says. Or maybe the article is incorrect or has a problem with it. That's why they give the

reference there, so --

Q. Right. But that's not a reason to doubt. That's you assuming that there could be something wrong with the citation. I'm asking you if you have an actual reason, evidence-based reason to doubt.

A. Oh, yeah. Absolutely.

Q. What is your evidence?

A. Well, the CDC, it says that its recommendations are based upon poor quality insurance. And I think actually, in their recommendation, they talk about, it's based on level four evidence, I believe was the drug screens.

And that's evidence where they expect the outcome to actually be -- likely to be different than what the estimated would be. So they're really saying they're basing their recommendations on low quality evidence that might be the opposite of what it says. So that tells me --

Q. Does that apply to the paragraph that you cut and pasted out of these guidelines into your report in this case?

A. I'm sorry. I was still talking. Can I finish my statement?

Dr. Murphy

Q. Once you answer that question.

A. I -- I forgot my question.

Q. Sure.

MR. HENESY: Can you read it back for me, please, Ariella? Thank you.

(Whereupon, the referred-to question was read back by the Reporter.)

THE WITNESS: I'm sorry. Does what apply?

BY MR. HENESY:

Q. The poor quality of evidence upon which these guidelines are based.

MR. CONROY: Objection. That's not what he testified.

MR. HENESY: Well, the record will speak for itself, what he testified.

THE WITNESS: The recommendation itself is based upon poor quality evidence. The wording that I lifted from the guideline, which I liked, was, I thought, a very accurate statement, that's why I used those words. So some of the phrases that they used, I'm very happy with, and they expressed the meaning very, very well.

But the evidence and the authority of

some of these recommendations, the specific recommendations, by the CDC's own admission, are based on low quality evidence. So what you're asking me to do is to compare apples to oranges, and I can't do that.

The statement that I used in my report is a very good statement, and I stand by that, the -- it stands on its own. But the evidence and the studies that they point to are not necessarily good studies or studies that I would put hope, tremendous stock in. Sometimes they're wrong.

And if you read the studies themselves, the authors are very candid that these studies don't prove anything. They maybe show a possibility. But the studies themselves are very candid about the lack of convincing evidence.

Q. Based on your own experience, Doctor, that highlighted sentence that's on the screen about the estimated cost in urine toxicology testing, in your experience, does that statement appear accurate to you?

A. It's across the board. It varies, what labs will charge. It varies. Some will be in the lower end, and I've seen tests that come back in the

thousands.

Q. Would you consider the thousands the higher end?

A. In my personal experience?

Q. Yes, sir.

A. Yeah. In my personal experience, I would consider it in the higher end. Personally.

Q. Doctor, in your own pain practice, you do not order simultaneous reporting -- you do not order drug screens where the results will be reported to you simultaneously for both an IA and an LCMS, correct?

A. I don't know. I might. Some of the labs might do that.

Q. Do you, as a matter of practice, Doctor, order presumptive and definitive drug screens on the same samples simultaneously?

A. I have in the past.

Q. How often would you say you do that?

A. Currently, I don't think it's very often anymore. I used to do it on a more frequent basis.

Q. You believe, Doctor, that decisions regarding

the -- whether and to what extent urine drug screens should be ordered should be based on the particular circumstances of the patient, right?

A. I think that is the overriding and most important determination.

Q. Doctor, you believe that -- it's your opinion that urine drug screens are not proven to benefit patient care, correct?

A. Not in every circumstance.

Q. For instance, you believe that urine drug screens do not provide accurate information about how much or what dose of a drug a patient took?

A. Correct.

Q. You believe that evidence demonstrating the effectiveness of urine drug tests for risk mitigation during opioid prescribing for pain is lacking, correct?

A. Yes.

Q. You agree that the CDC does not recommend a one size fits all approach for urine drug testing, correct?

A. Yes.

Q. You believe that the CDC says that the

urine drug testing should be a product of individual decision making, correct?

A. Yes.

Q. You believe that the CDC says that urine drug testing -- that in the context of urine drug testing, different choices will be appropriate for different patients, correct?

A. Yes.

Q. You also know that urine drug testing can be the subject of misinterpretation and might sometimes be associated with practices that might harm patients, correct?

A. Yes.

Q. You agree, Doctor, that drug screens should be done in consideration of the circumstances and unique needs of each patient, correct?

A. Yes.

Q. You believe that drug screen results can be misleading, correct?

A. Yes.

Q. You believe that while drug screens are important in the care of patients, of pain patients who use opioids to control their pain, to use drug screen data beyond their legitimate capacity is to

be both scientifically and ethically dishonest, correct?

A. Yes.

Q. In your own practice, it is your practice to utilize random urine drug testing, correct?

A. Yes.

Q. You agree, Doctor, that it is important for a doctor to document what happens on any given patient visit, correct?

A. Yes.

Q. You agree it's important to be complete in those records, correct?

A. Not necessarily.

Q. Earlier this year, you testified in a criminal case against an individual named Freeda Flynn, correct?

A. Yes, I testified in that case.

Q. And you testified on -- as an expert for the defense. Is that correct?

A. Yes.

Q. Do you recall being asked these questions and giving these answer?

"QUESTION: It's important to document

Dr. Murphy

what happens on any given patient visit, right?

"ANSWER: Yes.

"QUESTION: And as you discussed before, it's important to be complete, right?

"ANSWER: Yes.

"QUESTION: It's important to be accurate?

"ANSWER: Yes."

Do you recall being asked those questions and giving those answers?

A. No. I was asked a lot of questions. But if you want to show me the transcript, I'll be happy to look at it. I don't recall specifically what I was asked.

Q. Sure.

MR. HENESY: We'll mark this as Exhibit 4.

(Whereupon, Plaintiff's Exhibit 4, Transcript of the doctor's testimony as part of the Freeda Flynn case, was marked for identification as of this date by the Reporter.)

BY MR. HENESY:

Q. Okay. I've highlighted -- I'm on Page 155 of Exhibit 4. Let me go back to the top

for a second. For the record, this is a transcript of the doctor's testimony as part of the Freeda Flynn case which was in the U.S. District Court for the Southern District of Ohio on January 6, 2023.

And again, going down to Page 155, Doctor, I've highlighted those questions and answers I've just read to you. Please read those. And then let me know when you're done.

A. Okay.

Q. Okay. Having read that -- read those highlighted portions of the transcript, does it refresh your recollection that that's the testimony you gave in the Freeda Flynn case in January of this year?

A. I don't remember being asked those specific questions, but I do recognize that transcript.

Q. Okay. You were asked under oath in this trial in this course of questions concerning documentation of patient visits whether or not it's important to be accurate, and you testified under oath that it was important to be accurate in this trial, did you not?

A. I -- it says here, the question: "It's

Dr. Murphy

important to be accurate?" And my answer was "Yes."

Q. Okay. You don't deny that you gave that testimony, correct?

A. I stand by that statement. I'm not sure if that's exactly what I said. But I -- I will verify that that's truth.

Q. But now you're not sure. And now when I ask you the question of whether or not it's important to be accurate, your testimony is not necessarily?

A. No, it's important to be accurate.

Q. Okay. That was my question. Then if your answer is yes, it's important to be accurate, we can move on.

Doctor, you agree that individual confirmatory testing can be expensive, correct?

A. Yes.

Q. And you agree with me that a common practice in testing is to first screen samples using an inexpected [sic] presumptive test to rule out likely negative samples and then confirm potential positive results using a highly specific definitive test?

A. I think you misspoke a word. So you

Dr. Murphy

may want to ask that again.

MR. HENESY: Can you read it back for me? I'm happy to ask the question again, but let's see if I misspoke.

You know what, I'll withdraw it and I'll say it again.

BY MR. HENESY:

Q. You agree, Doctor, that common practice in testing is to first screen samples using an inexpensive presumptive test to rule out likely negative samples and then confirm potential positive results using a highly specific definitive test?

A. Yes.

Q. Or you agree, Doctor, that for routine clinical use, point of care testing is efficient and economical?

A. It depends.

Q. You don't agree with the statement that for routine clinical use, point of care testing is efficient and economical?

A. It depends on the circumstances.

Q. Okay. So as of -- you don't agree with that statement as a general rule?

A. Can I hear the statement again?

Dr. Murphy

Q. Sure. For routine clinical use, point of care testing is efficient and economical.

A. It depends.

Q. Okay. And so you would never write that in a report as a general rule, right?

A. I didn't say that.

Q. Okay. But if it depends, you don't think it's a general rule, right?

A. It could be a general rule. But not in every case.

Q. Okay. Well, my definition of a general rule is that it's true in every case. So using that definition, then you don't think that this is a general rule?

MR. CONROY: Objection as to form. I'm not going to let him answer a question where you make a definition that's completely subjective on your part. That's not an appropriate question, Steve. You've got to rephrase it.

BY MR. HENESY:

Q. You can answer the question, Doctor.

A. I can't answer the question the way that it's asked.

Q. Okay. Do you believe that it's true in

Dr. Murphy

every case that for routine clinical use, point of care testing is efficient and economical?

A. No.

Q. And you certainly have never presented that as a rule of general applicability in an expert report, right?

A. I have no idea.

Q. So you're not -- why would you present something in an expert report that you don't believe to be true?

A. I would never do that.

Q. Okay. So you don't think it's true that that's a rule of general applicability, so you would never present it as such in an expert report, right?

A. Would you ask me that a little more slowly?

Q. Sure.

MR. HENESY: Ariella, would you mind reading it back, and do me a favor, read it slower than how I said?

(Whereupon, the referred-to question was read back by the Reporter.)

THE WITNESS: Okay. I'm not going to

Dr. Murphy

answer that question because there are too many negatives and noes. I will give you a statement, but I can't answer it the way it's worded to me. I think it's a very difficult question to answer, and I would ask that it either be broken down or asked again.

BY MR. HENESY:

Q. Why don't we move on. You think, Doctor, that it's irrational to place too much clinical confidence in drug testing, don't you?

A. Yes.

MR. HENESY: We can go off the record for a second.

(Whereupon, an off-the-record discussion was held.)

BY MR. HENESY:

Q. Have you ever presented -- so I'm going to read you a sentence: "Urine drug screens are not proven to benefit patient care." Have you ever made that assertion as an expert, that urine drug screens are not proven to benefit patient care?

A. I don't recall specifically what I said in -- previously. However, I agree with that statement.

Dr. Murphy

Q. Okay. You're aware, Doctor, that as a general matter, a definitive confirmatory test can test for different numbers of substances?

A. Yes.

Q. And you know that a definitive drug test can test for one substance, 10 substances, or even 40 substances, right?

A. My assumption is that is correct.

Q. In your practice, when you're doing -- when you're ordering urine drug testing, you first do an in-office IA test, right?

A. No.

Q. Whether you're asking -- in your own practice, whether you're asking a lab to do a confirmatory test depends on the circumstances of each patient, right, in your own practice?

A. Yes.

Q. And you agree that most times, using a less expensive and readily available screening test will be sufficient when coupled with other relevant data? Most important would be a direct interview with the patient, right?

A. I think generally speaking, that is correct.

Dr. Murphy

Q. As a general matter, Doctor -- and I think you used this phrase before -- you consider patient care to be both an art and a science, right?

A. I think that patient care is a combination of art and science. Not two different things, it's a combination of art and science.

Q. Fair enough. Did you see any evidence in the records that you reviewed in this case of any of the practitioners making a notation that they suspected that the results of the IA screen contained a false positive?

A. Again, I can't remember the specifics of the report, so I don't recall any.

Q. Certainly, there's nothing in your report indicating that you identified any such instance, correct?

A. I don't believe there is.

Q. There is, however, a discussion in your report concerning your concern about potential false positives in the context of IA screening, right?

A. Yes.

Q. But you were noting that in there as a general matter. You weren't linking that to any specific evidence in this case, right? And when I

say "specific evidence," I mean specific evidence of a potential false positive.

A. Correct.

MR. HENESY: You know what, this is a good time to take a break. I'm going to leave it to the group. We can poll the audience on how much time everyone would like. I'm happy to take 45 minutes and come back at 1:30.

MR. CONROY: 1:30? Sounds good.

MR. HENESY: Is that reasonable?

MR. CONROY: How much time?

MR. HENESY: About 45 minutes, so 1:30. Is that fine?

THE WITNESS: That would be perfectly fine with me, yes.

MR. HENESY: Okay. See everybody at 1:30. Thanks.

MR. CONROY: Sounds good.

(Whereupon, a recess from 12:48 p.m. to 1:50 p.m. was taken.)

MR. HENESY: Back on the record.

BY MR. HENESY:

Q. Doctor, this is a phrase that you have used on several occasions when we were talking this

Dr. Murphy

morning. And you believe that the defendants in this case were utilizing what you termed as universal precautions, right?

A. Yes.

Q. Okay. The term "universal precautions," would you agree with me, has often been used in the context of risk mitigation in opioid pain management?

A. It's been used. I don't think a lot of people know about it.

Q. Mm-hmm.

A. But those of us who are experts in this field, many of us know about it. I certainly know about it.

Q. And would you agree that it's primarily applicable in the context of opioid pain management?

A. Yes.

Q. Certainly, you would agree that a physician does not have to have a diagnostic test result before they issue an opioid prescription?

A. Correct.

Q. Now, there's -- and we're going to talk about standing orders in a little while. But in your own words, can you -- as these terms are used

Dr. Murphy

in your report, please articulate the difference between a standing order and universal precautions.

A. Yes.

Q. Please do so.

A. A standing order is one means by with you -- by which you can practice universal precautions. A standing order, however, is also something that is used for efficiency and to standardize a group's approach to caring for patients, especially when there's more than one practitioner involved. So they're kind of reading off the same page.

And a standing order is an activity or something that is done in the practice. It could be a -- taking vital signs, it could be a test you can run, it can be a prescription, it can be any number of things.

But it has to do with the group is going to do this and they don't need a specific order each time they do it. This is our policy. We're going to go ahead and do this.

Universal precautions is a policy or a belief that you can reduce the stigma and increase the sensitivity of the tests or the therapy that

you're giving if you apply it evenly to the whole population.

And an example that's pretty obvious to people is in the HIV epidemic. When HIV was becoming known and it was not sure exactly how it was transmitted, it was initially thought to be primarily in the gay community. And we found out, over time, obviously, that it was in other bloodborne products, transfusions, whatever. And you couldn't really tell by looking at somebody or interviewing somebody whether they were infectious. We saw that with the COVID as well.

Because with COVID, a lot of times, you would be infectious and have no symptoms, yet we would universally ask you to wear masks. Again, there's a universal precautions approach. So it's -- it can have not only beneficial effect across the population, but also can reduce the stigma, and particularly associated with pain management and addiction as well.

Whereas, you know, the individuals that would come to a practice might feel that they are singled out or looked down upon because they are taking opioids and they're having a drug screen. A

drug screen, although we can say it's therapeutic as long as we want; for the patient, oftentimes, it feels like punitive or a police sort of activity. So they feel stigmatized. When the patient feels stigmatized, it can end up having a bad therapeutic outcome.

And, in fact, patients can end up not coming back to treatment because they feel ashamed or they do feel there is a stigma or a bias associated with that.

So applying these policies universally across everybody that comes into the clinic can decrease those barriers, improve patient care, and increase safety and diminish the barriers that get in the way of people having effective care.

Q. You would agree that best practice would be to have your standing orders in writing?

A. Yes.

Q. And to your knowledge, there were no written standing orders in this case, correct?

A. I don't -- I don't recall seeing any. I don't know if they existed or not. I don't recall seeing it.

Q. You're not aware of the existence of a

Dr. Murphy

written standing order in this case?

A. As I sit here now, I don't recall of any.

Q. Certainly, if you had seen a formal written standing order in the records that you were provided with, you would have included or at least made note of that in your report, right?

A. Well, I would have hoped to have done that. That would have been, again, an important thing to put in my report.

Q. So speaking of your report, in Exhibit 1, you have this language here. We're on Page 12 of Exhibit 1. I'm going to share my screen. And I'm focusing on this paragraph here that I've highlighted.

And it's the -- and for your reference, Page 11, this is under the section called Universal Precautions of Pain Management beginning on Page 11 and ending on Page 12. The last paragraph of it is a -- begins with a sentence "By adopting a universal precautions approach..."

Please read that up to and including the reference citation at the end of it, and then

Dr. Murphy

let me know when you're done.

A. I'm done.

Q. Okay. Now, the reference at the end of it is UNI. You see that, right?

A. Yes.

Q. So if we go to Page 15, which was the citations and we do the UNI citation, it's citing to a 2005 article by Drs. Gourley and Heit, correct?

A. Yes.

Q. Am I saying those names correctly, Gourley and Heit?

A. I believe so.

Q. So if we go now --

MR. HENESY: And this is going to be Exhibit 5.

(Whereupon, Plaintiff's Exhibit 5, Article, was marked for identification as of this date by the Reporter.)

BY MR. HENESY:

Q. So if we go back to that language we just read on Page 12, Exhibit 1. And on the left-hand side is Exhibit -- of the screen is Exhibit 5.

Doctor, is this the article that you

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were citing to in your report?

A. Yes.

Q. Okay. And this is by Drs. Gourley, Heit, and another doctor, Almahrezi, right?

A. Yes.

Q. And if we go down to Page 5 of the PDF, it says Page 111 at the top of this page. In the conclusion of this report, I've highlighted some language. Please read that and let me know when you're done.

A. I'm done.

Q. Okay. So I've put these side by side. And I'm sure you know why at this point. But you would agree with me that the language that appeared in your report on Page 12 that we just looked at is lifted word for word from the conclusion section of this article by Dr. Gourley, right?

A. If not, it's very close to it.

Q. You -- in reading both of these, you didn't identify any differences between the language, right?

A. It looks to be word for word.

Q. Okay. It's certainly not paraphrased, right?

Dr. Murphy

A. No. I don't think this -- this looks word for word.

Q. Okay. Now, you consider Drs. Gourley and Heit to be renowned pain and addiction specialists. Is that right?

A. Yes.

Q. Do you consider Dr. Gourley to be a colleague of yours?

A. Yes.

Q. And you've cited their work not only in this report here, but in other expert reports you've generated over the years, correct?

A. Yes.

Q. And by "their," I mean Drs. Gourley and Heit.

MR. HENESY: So I want to mark this as Exhibit 6.

(Whereupon, Plaintiff's Exhibit 6, Urine Drug Testing in Clinic Practice, the Art and Science of Patient Care article, was marked for identification as of this date by the Reporter.)

BY MR. HENESY:

Q. Okay. I've marked as Exhibit 6 a 32-page PDF document, the title being Urine Drug

Dr. Murphy

Testing in Clinical Practice, the Art and Science of Patient Care.

Have you ever seen this before, Doctor?

A. It does look familiar to me. But I -- yeah, I can't tell you that I've seen it before, but I may have.

Q. So if we go down to Page 2, do you see in the top left-hand corner here, the authors of this are Drs. Gourley, Heit, and one other doctor, Caplan. Do you see that?

A. Yes.

Q. Okay. Are you familiar with Dr. Caplan?

A. No, I'm not, that I'm aware of.

Q. All right. I'm going to show you some language in this report, in the introduction section on Page 4 of the PDF, Page 2 of the article. And it says -- here, I've highlighted it. It says, "Any test, including UDT, must meet the basic standards of medical necessity if it is to be a credible element of clinical care."

Do you see that?

A. Yes.

Q. And do you agree with that?

Dr. Murphy

A. I think that is a correct statement.

Q. Let's go to Page 3. On the bottom of Page 3 of the article, Page 5 of the PDF, I've highlighted a sentence that says, "However, the aim is not to test for every drug that is available for analysis, but to do medically necessary and reliable testing for those drugs that are most likely to impact clinical decisions."

Do you see that?

A. Yes.

Q. And do you agree with that statement?

A. Almost. I would be very close to agreeing with that.

Q. Further down, or on the next column over, still on Page 3 of the article, Page 5 of the PDF, it says, "The UDT method chosen should be a function of the questions that need to be answered. It is important that clinicians understand the methods for UDT in order to rationalize -- rationally order and interpret tests."

Do you see that?

A. Yes.

Q. There's two sentences. So in fairness, let's take the first sentence. "The UDT method

chosen should be a function of the questions that need to be answered."

Do you agree with that?

A. Yes.

Q. Okay. The second sentence: "It is important that clinicians understand the methods for UDT in order to rationally order and interpret results."

Do you agree with that?

A. Yes.

Q. Let's go down to Page 4. Page 4 of the article, Page 6 of the PDF, under the section called Laboratory-Based Specific Drug Identification. I'm going to read this into the record.

"Generally, a more definitive laboratory-based procedure (eg, GC/MS, LC/MS) to identify specific drugs and/or their metabolites is needed in three instances:

"(1) to specifically identify the drug where class alone is insufficient; for example, that is actually is prescribed morphine that is accounting for the positive immunoassay class response (rather than some other opioid or cross-reacting substance).

Dr. Murphy

"(2) to identify drugs not otherwise included in other tests."

And "(3) when results are disputed by the patient (ie, contested results)."

Do you see that?

A. Yes.

Q. Okay. Do you agree with that?

A. I'm close to an agreement with how that's written.

Q. Okay. What about it would you change?

A. Well, I would change -- in the first sentence, I would change the word "is" to "may be needed."

"Is" is -- to me, it denotes absolute, and I think there is some gray area there.

Q. Okay. So if we changed this to, "to identify specific drugs and/or their metabolites may be needed" in three instances, you would otherwise adopt this?

A. Yes. I would add one more word, though, or two more words. May be needed in three instances, and I would say "for example." Or I would say get rid of the word "three." For example, these three instances. Because I think those are

three very appropriate instances where you would do that, but there are more as well.

Q. Okay. So you -- to the extent that this sentence is saying that these are the three instances in which a confirmatory test is going to be necessary, you disagree with it?

A. Well, there are more instances than just these three, yes. And I would be surprised if somewhere in this article, there wasn't some disclaimer that says this is not standard of care, this is their recommendations, something of that nature. So this is not a clinical guideline. This is, I think, an opinion piece by these three doctors. So it's not hard and fast rules.

Q. Right. But it's an opinion piece -- you're saying it's an opinion piece by two doctors who you respect and who you have previously referred to as renowned pain and addiction specialists, right?

A. Absolutely.

Q. Okay. If we go down to -- okay.

You previously agreed with the assertion, which is the first highlighted portion of these materials, that said that any test including

Dr. Murphy

UDT must meet the basic standards of medical necessity if it is to be a credible element of clinical care.

Here on Page 9 of the article and Page 11 of the PDF, I've highlighted a sentence that says, "To meet the basic standards of medical necessity, it is important to ask, answer, and document why the test was ordered, what results were obtained, and what changes in clinical course were made (if any) as a result of the test results."

Do you see that?

A. Yes.

Q. Do you agree with that?

A. Yes.

Q. Let's talk about standing orders. We'll go back to your report. We'll go back to Exhibit 1. We're on Page 12 of Exhibit 1, which is the beginning of the Standing Orders section.

If we go back -- sorry, hang on one second. Let me just take a minute. Let's go back to Page 11 of your report. And we're in the Universal Precautions in Pain Management.

And I want you to read from "Creating a UDT policy that is applicable universally" -- it's

the beginning of this paragraph -- all way through this citation here that says "AROP." So please read that first section of this paragraph, and let me know when you're done.

A. I'm done.

Q. Okay. So AROP, if we go down to Page 15, which is the citation there on Page 11, AROP is a citation to the American Society of Interventional Pain Physicians, (ASIPP) Guidelines For Responsible Opioid Prescribing in Chronic Non-Cancer Pain: Part 2: Guidance Pain Physician. It's a long title.

Do you see that?

A. Yes.

(Whereupon, Plaintiff's Exhibit 7, Article from the ASIPP, was marked for identification as of this date by the Reporter.)

BY MR. HENESY:

Q. I have marked now Exhibit 7 which is -- if you take a look at this, Doctor, this is the article we just looked at, right, from the ASIPP?

A. Yes.

Q. And if we go down -- and this is a

50-page PDF, but we're going to look at particular sections of it. If you go to Page 10, the bottom of Page 10, and I'm going to put this -- what I'll do is I'll put this side by side. It's our previous article.

We're back on Page 11 of your report in Exhibit 1 with the language you just read, beginning "Creating a UD- -- PT policy [sic]," ending in what is -- "It is also a monitoring tool for safety." I've highlighted in the ASIPP article language that I'd like you to read.

And when you read it, please see if it's the same language that appears in your report.

A. I'm done.

Q. Okay. It is the same language, right?

A. It's very close. It's almost exactly the same language.

Q. Okay. And so did you read this whole ASIPP article?

A. No, I haven't read the entire article.

Q. Okay. It wasn't important to you?

A. Well, I didn't need it to find that language that I really liked and agreed with.

Q. Right, because you found language in

Dr. Murphy

here that supported your position in this case, so that was what you read?

A. I found language that -- that I felt properly conveyed my opinions, and then I provided the reference to where it came from so that anybody can go back, like you did, and see where it came from.

Q. Let's take a look at some other language in this report. If you go down to Page 11, on the left-hand side here, it says -- I've highlighted, "If a patient admits that they have used an licit or illicit drug other than prescriptions, and if that drug is testing positive, there is no need to confirm this with laboratory testing."

Do you agree with that statement?

A. Not always. Not in every case.

Q. Oftentimes, that can be true, right?

A. It depends on the circumstances. That -- it depends on the physician's decision on whether or not they want to accept that and how they're using the drug screen in the context of taking care of that patient.

Q. All right. I'm going to go back to

Dr. Murphy

Page 4 of your report where you list the patients you reviewed, the patient files you reviewed. And we'll take it in order, what's in here.

The first patient you see on Page 4 is WV, right?

A. Yes.

Q. Okay. Why don't we take a look at -- okay. So what I've marked here is -- I'll state for the record that this is a 100-page PDF that was provided to me from Mr. Hewitt and was represented to me as the materials reviewed by the witness inasmuch as patient files are review -- were concerned, and in particular, the patient files that were referenced in the witness's report.

So I'll zoom in a little bit. Doctor, can you see what I've marked here as --

MR. HENESY: This is Exhibit 8.

(Whereupon, Plaintiff's Exhibit 8, Medical reports, was marked for identification as of this date by the Reporter.)

A. I see a record in front of me.

Q. I just want to make sure that you see it in front of the screen clearly. I'm going to ask you specific questions about it. I'm going to

direct your attention to the middle of the page here. It's listing a patient name W[redacted] V[redacted], right?

A. Yes.

Q. And that's the WV that you reference in your report, right?

A. I don't know.

Q. Let's go back to your report, Exhibit 1, Page 4. Do you know the names of the patients that you reviewed?

A. Not as I sit here now, I don't know their names.

Q. Is there a document that might refresh your recollection as to the names of the patients that you reviewed?

A. Possibly. I don't know.

Q. Let's look at W[redacted] V[redacted] anyway, since we're here. So what I want to show you here on Page 2 of this PDF is there's a series of CPT codes with a description of what was provided, and the date of service, and the location of the service, and the amount that was charged.

Do you see that?

A. Yes.

Dr. Murphy

Q. Okay. By the way, we've looked now at Page 1 and Page 2. Have you ever seen this before?

A. I don't know.

Q. Doctor, there was a question I neglected to ask you. During our lunch break today, did you discuss -- did you speak with anybody during our lunch break today?

A. Yes.

Q. Who did you speak to?

A. Mr. Conlin [sic]. And I also spoke with my wife.

Q. Do you mean Mr. Conroy?

A. Mr. Conroy, sorry.

Q. Okay. And did you discuss your testimony with Mr. Conroy?

A. I didn't discuss it. He said something to me.

Q. What did he say?

A. He said something to the effect of you're doing okay, or something like that.

Q. And what did you say in response?

A. I just -- I think I just said thanks. I'm just telling the truth. Something like that.

Q. Did you ask any questions?

A. No, I don't think I asked any questions. Oh, I think I asked him -- I think I said, can I -- can we talk? Can I speak with you? And he said yes, it's fine. So, you know, I know that there's different rules and different lawyers have different things.

I know enough not to talk about any specifics of the case or even look things up while I'm still on the stand, so there was nothing material other than what I just mentioned discussed.

Q. Okay. I'm going to scroll down in these records. Let's look at these records. We're back -- I need a five-minute break.

MR. HENESY: Let's take a five-minute break and we'll come back just after 2:30.

(Whereupon, a recess from 2:26 p.m. to 2:33 p.m. was taken.)

MR. HENESY: Back on.

BY MR. HENESY:

Q. Back on Exhibit 8, which is this 100-page PDF with this patient W[redacted] V[redacted]. We're on Page 2. Okay.

Do you see, Doctor, that on Page 2 of this document, it indicates that this -- that a

trigger point injection, a lumbar ESI, epidurography, and a separate line item for fluoroscopic guidance were provided to this patient on April 3, 2019, correct?

A. Yes.

Q. Okay. So if we go down, it says "Treating Provider's Name" on Page 3. It says Allan Weissman. Do you see that?

A. Yes.

Q. If we go down even further, okay. So now we're on Page 5 of the 100-page PDF. At the top, it says, "Accelerated Surgical Center of North Jersey, LLC." And it says "Procedure Report."

Do you see that?

A. Yes.

Q. And would you -- taking a look at this, Doctor, would you agree with me that this is a procedure report from a lumbar ESI under fluoroscopy provided to this patient, W[redacted] V[redacted]?

A. Yes.

Q. And do you see at the top here where it says "Physician," it says "Allan Weissman," right?

A. Yes.

Q. And it says the anesthesiologist was

someone named a Marsha Copeland, right?

A. Yes.

Q. Okay. And that the procedure report is signed towards the -- have the signature of Allan Weissman on it, right?

A. Yes.

Q. And if we go to the next page, Page 6, generally speaking, Doctor, reviewing this, this appears to be the epidurography procedure report from that same day, again listing Dr. Weissman as the surgeon and Dr. Copeland as the anesthesiologist, right?

A. Yes.

Q. Page 7, another procedure report. This one for bilateral trigger point injections on the cervical paraspinal muscles, right?

A. Yes.

Q. And again listing Dr. Weissman as the physician and listing Marsha Copeland as the anesthesiologist, correct?

A. Yes.

Q. Again, all of this happening on April 3, 2019, right?

A. Yes.

Q. Next page. Certainly, Doctor, you've seen pages that look like this before, right?

A. Yes.

Q. This is, you know, a very standard looking anesthesia record, right?

A. Yes.

Q. And you see that it's dated April 3rd of 2019 with respect to this patient W[redacted] V[redacted]. Do you see that at the top right-hand corner, right?

A. Yes.

Q. Okay. Do you see on this report there's a section on the right-hand side for a preanesthesia evaluation, right?

A. Yes.

Q. And you see that there's a section to list any medication the patient is taking, right?

A. Yes.

Q. And there's nothing listed, right?

A. It's -- the line is blank.

Q. Okay. There are certainly other markings in the preanesthesia evaluation section, right?

A. Yes.

Q. And so if we continue down, I want to

show you now, starting on Page 15, this is another bill, again, with respect to W[redacted] V[redacted].

Do you see that?

A. Yes.

Q. Okay. Have you ever seen this before?

A. I don't recall. I don't recall seeing it.

Q. Do you recall seeing any of the pages that we've looked at so far?

A. I mean, not specifically. I looked at a lot of pages so I don't specifically remember those pages.

Q. Okay. Now, Page -- we're going to scroll down now. Okay. Now we're on Page 20. And do you see on Page 20 there's a toxicology test requisition form?

A. Yes.

Q. Okay. And at the top of the toxicology test requisition form, it says Gorman, right?

A. Yes.

Q. Next to provider, right?

A. Yes.

Q. And this toxicology requisition form actually indicates a number of things. The first

thing it indicates is that -- if you look on the right-hand side here, that a point of care screening test appears to have been provided to this patient, W[redacted] V[redacted], right?

A. Yes.

Q. Okay. And you see that this is dated April 3, 2019, right?

A. Yes.

Q. The same day as that procedure, or that series of procedures for the report that we just looked at earlier in this PDF, right?

A. Yes.

Q. And you see that the -- that for this point of care test, it tested for 14 different categories of drugs, right?

A. Yes.

Q. And it was negative for all 14?

A. Yes.

Q. And you -- we've touched on this throughout our discussion today, you understand that a point of care test is going to use IA technology that's similar to an IA test that's done in a lab, right?

A. Yes.

Dr. Murphy

Q. And it's going to give you a binary positive/negative reading for classifications of drugs rather than specific drugs, right?

A. It can give you specific drugs.

Q. Okay. For instance, this is listing -- well, give me an example of what you see on here of what you would say is a specific drug result.

A. BUP, buprenorphine.

Q. THC?

A. THC is -- is just the chemical THC. So it would not be a specific drug.

Q. Certainly, it's oftentimes indicative of marijuana, but I take your point. Fine.

But as a general matter, the point of care test is certainly less precise than an LCMS test?

A. Correct.

Q. Now, you see that this patient was given a point of care test and it was negative across the board, but it's checked off in Section B on the left-hand side for the lab to do a screen qualitative testing for, depending on how you're defining it, either nine or ten drug categories, right?

Dr. Murphy

A. Yeah. There's a check mark there to -- it says screening all with validity. And then it gives the medications there. And they're slightly different than on the POCT screening.

Q. Certainly significant overlap, though?

A. Yes.

Q. In addition, this toxicology test requisition form indicates that a confirmation for quantitative results is being requested as well. And it says -- next to it, it says "confirm all."

You see that, right?

A. Yes.

Q. Okay. You also see that the individual filling out this form has the ability to check off individual drug categories in the confirmation section of the form, right?

A. Yes.

Q. They could ask for a confirmation of just amphetamines, right?

A. Yes.

Q. They could ask for a confirmation of just opioids and opiates, right?

A. Yes.

Q. And so on and so forth. They could

Dr. Murphy

also ask for a confirmation of just those substances that come up positive on the screen, right?

A. It's not exactly the same. For example, I don't see cocaine metabolite down on the confirmation. I just see illicits. So that could be what it is, but it's -- they're not exactly the same, but they're close.

Q. Well, so -- but you see on the left-hand side, the first box on the top left-hand corner of the confirmation of the form says "Confirm positive screening results." You see that, right?

A. Yes.

Q. Have you ever seen one of these forms before we started looking at it just now?

A. Do you mean this exact form?

Q. Let's talk about this first. Have you ever seen this exact form before?

A. I don't remember if I saw this exact form or not. I probably did. It's in the records, but I don't recall seeing it.

Q. Okay. But you had seen forms in -- that look like this?

A. In general? In my practice?

Q. No, in connection with this case.

Dr. Murphy

A. I am assuming I did. I looked at the records. If they're in the records, I saw them, probably. I don't remember exactly what I looked at sitting here right now.

Q. Okay. So there's a box on the right-hand side here that says "Medical necessity," and it gives four different justifications and then a line to fill in another justification that isn't listed.

Do you see that?

A. Yes.

Q. You see that's completely blank, right?

A. Yes.

Q. So looking at just this form -- well, let's do it this way. Looking at this form, you're unable to tell why this patient was getting both a qualitative and quantitative urine screen, right?

A. I can't see a specific reason except that the practitioner ordered it.

Q. Okay. Well, let's talk about that. At the bottom here, there's a section E that says "Practitioner Authorization." Can you see that?

A. Yes.

Q. Okay. And it says -- a line that says

Dr. Murphy

"Ordering Physician Signature." Do you see that?

A. Yes.

Q. And you see that it is blank, right?

A. Yes.

Q. And so refreshing your recollection that it's Dr. Gorman's name at the top of the form, do you recall earlier this morning, we looked at some testimony from Dr. Gorman or we discussed some testimony from Dr. Gorman wherein he indicated that if a requisition form wasn't signed, that he did not order the test, right?

A. I remember you saying that.

Q. Well, I mean, I'm saying it to you today. But you remember that Dr. Gorman testified to that under oath, right?

A. Only that you told me today. I mean, I don't remember -- I looked at his -- the testimony, but I don't remember exactly what it was sitting here today.

Q. Sure, let's go back. Exhibit 2. I'm going to highlight in Exhibit 2. We're on Page 42, Lines 14 to 22.

"QUESTION: Just so that I understand your testimony, if a lab referral doesn't have your

Dr. Murphy

signature on it, you would deem that to be unauthorized?

"ANSWER: If a lab referral doesn't have my signature, then I didn't order it.

"QUESTION: Even if at the top of the referral, it had your name on it?

"ANSWER: No. Prescriptions have to be signed."

You see that, right?

A. Yes.

Q. So now going back to this document, we have Dr. Gorman's name at the top of a toxicology test requisition, but he didn't sign it. And he said under oath that if he didn't sign it, he didn't order it. He didn't authorize it. This is an unauthorized test, isn't it?

A. No, not necessarily.

Q. So you believe that Dr. Gorman authorized this test?

A. No, I don't know whether he authorized it or not.

Q. Well, based on his testimony -- assume for a second that Dr. Gorman was telling the truth when he said if his signature wasn't on the form, he

Dr. Murphy

didn't authorize it. I'll ask my question again.

Assuming that is true, this is an unauthorized test?

A. Not necessarily.

Q. Okay. So you see evidence on this form before you that Dr. Gorman authorized this test?

A. Yes.

Q. What -- show me the evidence on this form that Dr. Gorman authorized the test.

A. His name under "Provider."

Q. Let's go back to his testimony.

"QUESTION: Even if at the top of the referral, it had your name on it?

"ANSWER: No. Prescriptions have to be signed."

Okay. Let's go back. His name is on the top of the form and it is not signed, and your evidence that this is an authorized test was that his name is at the top of the form?

A. I believe that is evidence that it's authorized, yes.

Q. Okay. Besides his name being on the top of the form, tell me the other evidence you see on this document to indicate to you that this is an

authorized test.

A. There's a diagnosis code on the top right, and I'm not sure what they mean, but they probably mean something that helps with the diagnosis. So that would be part of the authorization.

Q. Okay. So because there are two check boxes under diagnosis codes, that indicates to you that Dr. Gorman authorized this test?

A. No.

Q. All right. I'm asking you, Doctor -- let's make sure that my question is clear. I'm asking you, looking at this document, to tell me the evidence that you see -- besides his name being at the top of the form, the evidence you see that this test was authorized by Dr. Gorman.

A. By Dr. Gorman, the evidence that I see that -- by Dr. Gorman is his name at the top.

Q. Right. And besides that, there is no evidence on this document that Dr. Gorman authorized this test?

A. No, not on this document.

Q. Let's go to the next page. The next page is the first page of -- well, do you recognize

Dr. Murphy

this? What's on Page 21 here?

A. It's a lab report, a drug screen report.

Q. Have you ever seen it before?

A. Possibly. I don't recall specifically seeing it.

Q. Do you see that the collection date listed on the top of this report is listed as April 3, 2019, right?

A. Yes.

Q. And that was the date of those procedures that we just looked at, right? The ESI, the TPI, the epidurography, the fluoroscopy, that was all April 3rd, right?

A. Yes.

Q. Do you see that under "Collection Date," it says "Receive Date" of April 4, 2019, right?

A. Yes.

Q. And that indicates to you that's the date the lab received the sample, right?

A. That's how I interpret that.

Q. And then the next line is "Test Report Date": April 5, 2019, right?

Dr. Murphy

A. Yes.

Q. Now, on this report, two sets of results are listed. You would agree with me that the first set of results that are listed are the qualitative screen -- the IA screen results that were on the requisition form. You see that, right?

A. To answer your question, do I see that, I see what you just pointed out to me.

Q. Okay. Do you interpret that as the results of the IA screen?

A. I don't see where it says what it is.

Q. Okay. So as you sit here, you don't know what this is?

A. It says "Drug Screen Result."

Q. Okay. But I'm asking you, does this look like the results of an IA screen?

A. It looks like the results of an IA screen.

Q. But you're not sure?

A. Based on what I'm reading here, I'm not sure.

Q. If we go down, on the next page, it's Page 22. And I'll scroll through it quickly just to show you what I'm talking about. Page 22, 23, and

Dr. Murphy

24. Those are -- do you recognize what those results are?

A. It's more drug screen results.

Q. Okay. Do you know what kind of screen it was?

A. Yes. It's LCMS.

Q. I just want to talk about a couple of these categories. The category that's on Page 24 here that I'm highlighting is SSRI confirmation.

You see that, right?

A. Yes.

Q. You know SSRIs to be, you know, some of the commonly prescribed antidepressants that are available by prescription, right?

A. Yes.

Q. And you -- and if we go to the bottom of Page 23 where it says "sleep aids confirmation" and then the next line down, there's two more lines of "sleep aid confirmation." These are commonly prescribed sleep aids, Zolpidem probably being the most common, right?

A. Yes.

Q. When you order a drug screen at your practice, do you order a confirmation screen for

Dr. Murphy

SSRIs and sleep aids every time?

A. No.

Q. You make that determination based on the circumstance of every patient, right?

A. Yes, and my personal clinical judgment as well.

Q. Actually, do you recall ever ordering a drug screen, an LCMS drug screen, for sleep aids or SSRIs?

A. Yes.

Q. How frequently do you do that?

A. I haven't done it in a while. But I think I recall that back a few years ago, they kind of included them in the panel that they were running. And I'm not sure I even specifically remember ordering them, but I order a panel that has a number of drugs on there.

And they have a -- the companies have it set up to run these -- you know, a certain panel of them. And so it's added on with the panel. It's for completeness sake.

So I'm certain -- because I remember seeing reports of SSRIs and things of that on patients in the past the tests that I've ordered.

Dr. Murphy

But it's not something that I tend or I can even remember specifically ordering as individual drugs.

Q. When you order your drug screens and your lab-based drug screens like LCMS or gas chromatography, do you order them from one of the larger commercial labs?

A. It depends on the patient's insurance and their preference and where they're located. It varies. I try to work with the patients to make sure it's convenient for them, if I can, to have it done. And if the insurance can cover it, if possible. It varies.

Q. You're cognizant of not, you know, causing the patient to incur an expense in this regard?

A. It's important to me that they can afford it or that -- we factor that in to my decision making, yes.

Q. All right. So the reason I asked you about this test report date is that it's April 5, 2029 [sic], which is two days after the procedure that was done.

That timing, Doctor, that the results were not made available until two days after the

Dr. Murphy

procedure is done, wouldn't you agree that that -- in reviewing these documents, that rules out as a possible justification for the urine screen, that the urine screen was done to see if the patient was a candidate for the procedure?

A. If the results are not available to -- after the procedure, then you can't use those results to determine if a patient is a candidate for that procedure. But you can use them going forward in case of future procedures.

And oftentimes, these procedures are done in procedures of two or three, so it would helpful to understand. Also, if a patient were to have a reaction at some point to maybe a local anesthetic that I gave during the procedure or the anesthesia they got, in determining why they had the reaction, understanding what the drug screen showed would help in that determination as well.

Q. Okay, fine. But my question specifically was the April 3rd procedure, the fact that that patient was getting a procedure that specifically happened on April 3rd could not possibly serve as a justification for this urine screen where the results were not available until

Dr. Murphy

April 5th. We can agree on that?

A. No, no. There could be a very good reason why they got the drug screen on that day.

Q. You think there's a good reason that a -- results that were available on April 5th can determine whether or not a patient was retroactively a good candidate for a procedure that happened two days earlier?

A. No.

Q. Okay. Thank you. I also want to show you on Page 25, 26, and 27 -- do you recognize these pages? 25, 26, and 27?

A. Not specifically, no.

Q. Do you see here, though, that there's a section of this document that says "Historical Results Confirmation"? Do you see that?

A. Yes.

Q. And you see that approximately two weeks before the April 5th results were reported for this patient, another set of -- another confirmatory panel of all of these same drugs was run on the same patient, right?

A. It seems to be that is the case, yes.

Q. So I want to show you -- and you can

Dr. Murphy

look, but I'm going to represent to you that next to each one of these drugs for both the March 18th confirmatory and the April 5th confirmatory panel, negative for every single drug across the board.

So I want to freeze a moment in time then. If we go back to the requisition form, right, I want to freeze it a couple of moments in time. This requisition form is dated April 3rd. At this point, the March 18th report -- the March 18th confirmation test has been run and the patient was negative for every single drug that was tested for on the highly sensitive and accurate LCMS test. The patient gets another point of care test that's negative across the board.

At that point, it certainly seems like this patient is not on any medications or drugs, right?

A. Not necessarily.

Q. Okay. Then in the April 3rd -- in the April 5th report, it's another test across the board. And another full confirmatory test across the board, negative across the board.

Okay. And at this point, certainly, you would agree with me that there's no reason to

believe that this patient is on any drugs or medication? Or let me rephrase that, any drugs or medication that were tested for?

A. There's no evidence here that they were on those drugs.

Q. And certainly no reason to suspect it if you were reviewing this, right?

A. Correct.

Q. Okay. Let's go to this page here, which is Page 37 of this PDF.

Can you see that clearly, Doctor?

A. Yes.

Q. Okay. Do you recognize this form? When I say "recognize this form," do you recognize the health insurance claim form 1500?

A. Yes.

Q. Okay. Is this the form you use for your billing?

A. I used to use this form. We've used it many, many times.

Q. Clearly, this is the form that you're going to use for a federal payer, right?

A. I believe that is correct, yes.

Q. So do you see on the top left-hand

corner here, there's a patient named J[redacted] V[redacted]?

A. Yes.

Q. Do you see that?

A. I do, yes.

Q. Is this one of the records that you reviewed as part of your review in this case?

A. I don't know.

Q. So I want to go down and just scroll through this. So it starts on Page 37. 38 is an additional claim form. 39 is an additional claim form. I'll represent to you that these are all the same dates of service of November 20, 2018. Okay.

And so now we go to another one of these Ridgewood Diagnostic Laboratory reports, right? This looks like the one we just looked at.

A. Yes.

Q. And this is another one ordered by Dr. Gorman?

A. It says the provider is Dr. Gorman.

Q. Right. Okay. Certainly, if we look through this -- that's the end of the record, on Page 47.

So from Page 34 to 47 -- excuse me, 37 to 47, are these -- is bills and then a toxicology

report from Ridgewood Diagnostic Laboratory for J[redacted] V[redacted]. Test report -- collection date of November 20th, test report date of November 27, 2018.

Looking at this document, Doctor, there's certainly no indication in this document as to why this test was ordered, right?

A. Can I see the very bottom of it there? Scroll up.

Q. Tell me -- here? (Indicating.)

A. Yes, thank you. Yes, I don't see an indication on this form as to why the test was run.

Q. And so to the -- you know, even if this were one of the records that you reviewed as part of your analysis, it would not be enlightening inasmuch as giving you information about why this test was ordered and the circumstances under which the test was ordered, right?

A. This one piece of paper would not.

Q. Well, I mean, I'm talking about this whole report. You can look at all the pages if you think there is something in here. We just scrolled from Page 42 to 43.

A. I see nothing on that page.

Dr. Murphy

Q. Okay. Next page, 44.

A. I see nothing on that page.

Q. Okay. 45.

A. I see nothing on that page.

Q. 46.

A. I see nothing on that page.

Q. 47.

A. I see nothing on that page.

Q. Okay. All right. So Page 50 is a very faded document, but it's a faded version of the health insurance claim form 1500. But I want to go down. You recognize the boxes on the bottom of the 1500 form list the service provider and the billing provider for the particular service.

You're generally familiar with that?

A. Yes.

Q. Okay. And it's listing an entity called Metropolitan INT Medical Services PC.

Do you see that?

A. Yes.

Q. Are you familiar with Metropolitan?

A. I don't recall what Metropolitan is.

Q. Are you offering an opinion in this case concerning any of the services provided or

billed through Metropolitan?

A. I'm sorry. I'm offering services -- I'm offering opinions on the medical necessity and appropriateness of the drug screens.

Q. Right. So I'm just making sure, you're not offering an opinion about services provided through an entity called Metropolitan Intervention Medical Services PC, correct?

A. Well, I was given a group of records and I looked through them. And in that group, I did not see any drug screenings that I felt were not medically necessary. So whatever ones were in there, I don't recall specifically seeing Metropolitan Internal Medicine Services on there, but they may have been.

Q. This particular page, 5, of this document, have you ever seen this before?

A. I don't recall seeing that faded document, no.

Q. Well, do you recall reviewing records with respect to a patient named I[redacted] E[redacted]?

A. I don't recall their specific names.

Q. Okay. Now we are on Page 60. Page 60 is a document where, at the top, it says Riverside

Medical Services, and it says "Initial Comprehensive Medical Examination." Do you see that, Doctor?

A. Yes.

Q. And it lists a patient M[redacted] R[redacted]?

A. Yes.

Q. Have you ever seen this document before?

A. I don't know.

Q. All right. Was M[redacted] R[redacted] one of the patients you reviewed medical records for?

A. It could have been. I don't specifically recall right now.

Q. So I want to go through just a few things on this document, Doctor. Do you see it says, "Initial Comprehensive Medical Examination"? And generally speaking, you see that this document includes some handwritten notations on what appears to be a template for a patient exam, right?

A. Yes.

Q. Okay. For this patient M[redacted] R[redacted]. And you see here it's listed as May 30, 2019, next to date of initial examination, right?

A. It could be 31 or 35. It's 5/3, something, 19.

Dr. Murphy

Q. I think we can probably agree it's not May 35th, right?

A. Well, I see a squiggle there. So I would be -- it would be a mistake if it said May 35th.

Q. That was a joke that does not translate well on transcripts. So that was a poor attempt at a joke.

So -- and you see here DOA. You know that's date of accident. And that says May 29, 2019, right?

A. Well, there's two dates there. One looks like it's 5/29/19, and then below it, 5/20 -- it looks like it was 5/28 and then changed to 5/29. It would appear -- I would interpret that as 5/29/19.

Q. Okay. So if we're -- if you're assuming for purposes of this discussion that that says May 30, 2019, as the date of the exam, this is an exam that was done the day after or maybe even two days after an accident, right?

A. Yes.

Q. Okay. Do you see that there's some patient history listed here, right?

Dr. Murphy

A. Yes.

Q. And then you see some subjective complaints, right?

A. Yes.

Q. Additional subjective complaints on the next page, 61, right?

A. Yes.

Q. Okay. We're on Page 62. Do you see the beginning of a past medical history, right?

A. Yes.

Q. And do you see there are two diseases listed on past medical history? Do you see that?

A. Yes.

Q. It certainly looks like -- well, let me tell you what it looks like to me and you tell me if you agree. It looks to me like hypertension and diabetes. Do you agree?

A. Yeah, HTM to me means hypertension. And it appears to me it says DM, like a little two. So probably Type 2 diabetes.

Q. And then it lists two medications, which might actually inform our interpretation of diseases, because there's a medication called metformin and a medication called losartan.

Dr. Murphy

Do you recognize those as diabetes and hypertension drugs?

A. Yes.

Q. Okay. So now, given those two points, it certainly looks like diabetes and hypertension for this patient, right?

A. Yes.

Q. Okay. Let me go further down. We see some objective findings here, right?

A. Yes.

Q. Okay. We'll go down onto Page 64, some more objective findings and measurements, right?

A. Yes.

Q. 65, more objective findings and measurements, right?

A. Yes.

Q. Okay. 66, we see a series of diagnoses that are checked off, right?

A. Yes.

Q. Okay. 67, we get a treatment plan. That includes physical therapy, physical capacity evaluation, computerized range of motion, manual muscle testing, an outcome assessment test, and MRIs, right?

Dr. Murphy

A. That would appear to be the case. I'm not sure what MMT means, but everything else sounds reasonable.

Q. Number 8, you also see that it looks like the practitioner doing this exam is recommending -- "because of the persistence of symptoms despite any active treatment, it's recommended that the patient get electrodiagnostic testing on the upper and lower extremities and the paraspinal." (As read.)

You see that, right?

A. Yes.

Q. Okay. Finally, on Page 68, you see that in addition to all of the services recommended, this patient is prescribed a cervical collar, a cervical pillow, a lumbar support orthosis, a heating pad, an orthopedic lumbar cushion, an orthopedic car seat, a TENS unit, and a massager.

You see all that, right?

A. Yes.

Q. I hope they have a big trunk in their car. And after that, it says "Medications Prescribed." Do you see that it says over-the-counter acetaminophen, 650 milligrams every

Dr. Murphy

six hours as needed, right?

A. Yes.

Q. So we have a patient who is examined between 24 and 48 hours after their accident who is prescribed a course of conservative therapy, and is prescribed an over-the-counter -- well, not prescribed. They were really recommended to get over-the-counter Tylenol, 650-miligram Tylenol, and to take it as needed.

Certainly on this form, Doctor, you haven't seen anything to suggest that the individual performing this examination was considering prescribing an opioid?

A. I didn't see anything.

Q. You -- we didn't see anything on this exam report that would indicate that the practitioner performing the examination was requesting a urine toxicology screen, right?

A. I didn't see anything.

Q. Much less any reason why the toxicology screen would need to be ordered, right?

A. Well, there is reason.

Q. No, no. As noted -- is there, I am ordering a urine toxicology screen because? It

doesn't say anything like that, right?

A. Correct.

Q. Okay. Now, the next page is Page 70 that we're looking at. And this is a May 30th toxicology test requisition form for M[redacted] R[redacted], right?

A. Yes.

Q. And despite the fact that the patient -- that there's no indication that a course of opioid was being considered, despite the fact that this patient was between 24 hours and 48 hours after the accident, despite the fact that they were not reported as taking any controlled substances, and despite the fact that they were not prescribed any controlled substances, do you see that this toxicology test requisition requests an IA qualitative screen and an LCMS confirmation for all of the drug categories listed on the form, right?

A. Yes.

Q. And again, nothing listed on this form to indicate to you why the practitioner ordered that testing?

A. Well, there's diagnosis codes. And I'm not sure. I would need to look those up to see what

Dr. Murphy

they mean. But the diagnosis codes are there, generally, to explain why they're getting the test. So we'd have to look up those codes.

Q. So you think the diagnosis codes with respect to, you know, an injury that was, at most, 48 hours old would justify, for instance, a quantitative LCMS test or SSRIs?

A. I have to see what those codes say. I'm not saying those codes would. But generally -- they checked those codes, so that's usually why they check them. But there's no -- nothing written on this form other than that that would tell me on this form why they're having the drug screening.

Q. Pages 71 through 77 are the results of the drug screen. All right?

MR. HENESY: Okay. Let's take five minutes. We will come back. We have got just a little bit more to go, okay?

(Whereupon, a recess from 3:24 p.m. to 3:39 p.m. was taken.)

BY MR. HENESY:

Q. We're still on Exhibit 8 on Page 80. Doctor, do you see on Page 80 here, we have a Riverside Medical Services initial comprehensive

medical exam for a different patient. It looks -- if we go down, it looks a little unclear.

It looks like S[redacted] A[redacted], right?

A. Yes.

Q. Okay. Is this one of the patients whose files you reviewed?

A. Again, I don't know the names of the specific patients right now.

Q. So this is an example that looked like it happened on September 3, 2019, right?

A. Yes.

Q. Okay. From an accident of August 30, 2019, right?

A. Yes.

Q. I'm going to skip through the subjective and objective findings. I want to focus on the past medical history here on Page 82. This is a patient who you see denies any history of disease, right?

A. Yes.

Q. Is taking Advil as needed, right?

A. That's Motrin, ibuprofen.

Q. Ibuprofen.

A. Generic, yeah.

Dr. Murphy

Q. Generic Motrin as needed, right?

A. Yes.

Q. Denies smoking, alcohol, or drug abuse, right?

A. It just says "denies smoking." I think it says "denies." It says -- it looks like occasional ETOH for alcohol.

Q. Right.

A. And denies drug abuse.

Q. Right. And if we go down through this, under additional objective findings and diagnoses, and if we get down to Page 88, do you see that there's a recommendation that this patient essentially continue to take over-the-counter Motrin as needed, right?

A. Yes.

Q. So no -- they didn't come in to present to the doctor or examining practitioner taking any controlled substances and is not prescribed any controlled substances, right?

A. Correct.

Q. And it doesn't say anything on here that the patient is being considered as a candidate for a controlled substances prescription, right?

A. I didn't see anything.

Q. All right. In your opinion, Doctor -- when is pain chronic, in your opinion?

A. In my opinion, it's when the pain persists -- either two things, either beyond the healing process or more than three months. And I think that would depend upon the circumstances what I would ascribe to a patient. But those are the two descriptive elements that I look at in determining chronic pain.

Q. Certainly, we see this exam happened within a week of the underlying accident. Certainly, this is not a person who is -- at this point, you would characterize this as being chronic, right?

A. Not from the accident, no.

Q. Right. Okay. To the extent that we're talking about injuries causally related to the accident. Okay. So if we go down, do you see -- we're now on Page 90. We've got another toxicology test requisition form for this patient S[redacted] A[redacted]. And do you see up here on the left-hand side, there's a date of September 3, 2019, right?

A. Yes.

Q. Okay. This patient gets that same full IA screen and full LCMS test that we've now seen repeatedly on these forms, right?

A. Yes.

Q. And we see, again, there's a box for medical necessity to the ordering practitioner -- or really, anyone -- to check off or indicate the justification that they see for ordering testing of this breadth and scope, and you see that it's blank, right?

A. Yes.

Q. There was no indication in anything that we just saw where the practitioner, with respect to S[redacted] A[redacted], indicated that they were ordering a urine drug screen for a specific reason?

A. Again, the only place I could see something like that would be under the diagnosis codes. In this case, there's four that are on the form. It would appear that all four of them have been checked on this patient.

Q. Besides that, though, nothing else, right?

A. I didn't see anything else.

Q. And certainly, in any of the documents

Dr. Murphy

that we've looked at, there would be no explicit notation in any of these records, a spelled out reason of why the urine screens were ordered in the first place, right?

A. In the records we've just gone over, those patients, I didn't see anything, except for the diagnosis codes that we talked about being checked on the top right-hand corner of the toxicology test requisition.

Q. The other thing that we didn't see in those records that I just showed you was anything beyond a single date of service during which the patient would have been with a practitioner.

So in other words, we saw records where -- you know, in the last two that we looked at, we saw two records, two sets of records for two patients who received an initial exam. And at the conclusion of the official exam or on the day of the initial exam, there's a toxicology test requisition form that's filled out for a urine screen for an IA and LCMS screen.

Certainly, we haven't seen any documentation here in these records that we just looked at to indicate that the results of these

urine screens were reviewed by the ordering practitioner, correct?

A. Not in what you just showed me. I didn't see anything.

Q. We didn't see anything in what we just looked at in that Exhibit 8 that would indicate that the results of the urine drug screens that were ordered were ever discussed with the patient, right?

A. I did not see that in these notes.

Q. We didn't see anything in those records that would indicate that -- we didn't see anything in those records to indicate that the results of the urine drug screens were incorporated into a treatment plan in any way, right?

A. I did not see language to that effect.

Q. In any of the materials that you reviewed in connection with this case, did you see an indication -- a notation in any medical records that the results of a urine screen were discussed with the patient?

A. I can't recall right now if I saw anything like that. So I can't recall.

Q. Did you see anything in any of the records you reviewed in connection with this case

Dr. Murphy

that a notation that the ordering practitioner reviewed the results of the ordered urine drug screen?

A. As I sit here now, I can't recall any documentation like that.

Q. In connection with this case, did you review any documents that stated that the results of the urine drug screen were being incorporated into the treatment plan for the tested patient?

A. Again, I can't remember all of the charts and all of the specific documents, but I cannot recall seeing that.

Q. And certainly, your report does not indicate or reflect that in the course of your review, you identified anything along the lines of what we just discussed?

A. I don't believe that I put that in my report.

MR. HENESY: Okay. I don't have any other questions for the witness.

Matt?

MR. CONROY: No questions for me. Thank you, Doctor.

MR. HENESY: Thank you, Doctor. Thank

Dr. Murphy

you, Mr. Conroy. We're reserving our rights to seek additional discovery, as always. Everyone have a nice afternoon.

(Whereupon, at 3:50 p.m., the Examination of this witness was concluded.)

Dr. Murphy

E R R A T A S H E E T

CORRECTION	REASON FOR CHANGE	PAGE	LINE

Dr. Murphy

DEPOSITION ERRATA SHEET

J U R A T

I declare that I have read the entire transcript of my deposition taken in the captioned matter or the same has been read to me, and it is true and accurate, save and except for changes and/or corrections, if any, as indicated by me on the Errata Sheet hereof.

_____
Dr. James Murphy

Subscribed and sworn to before me
This_____day of_____, 2023.

NOTARY PUBLIC
In and for the State of_____

Dr. Murphy

C E R T I F I C A T E

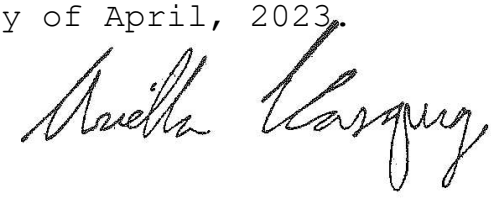
STATE OF NEW YORK)
: SS.:
COUNTY OF NEW YORK)

I, Ariella Vasquez, a Notary Public for and within the State of New York, do hereby certify:

That the witness whose examination is hereinbefore set forth was duly sworn and that such examination is a true record of the testimony given by that witness.

I further certify that I am not related to any of the parties to this action by blood or by marriage and that I am in no way interested in the outcome of this matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 27th day of April, 2023.



Ariella Vasquez